PANHANDLE AREA EDUCATIONAL CONSORTIUM

OCCUPATIONAL INJURY / ILLNESS WORK RELEASE

Employees Name:_____ SSN:_____ Date of Injury:_____

Visit Date:_____ Time In:_____ Time Out:_____ Follow up Visit Date/Time:_____

Employee can return to **Normal duties** now? ___YES ____NO If NO, When?_____
Employee assigned to **Transitional Work** now? ___YES ____NO If NO, When?_____

Employee is totally and permanently disabled from all occupations? ___ YES ___ NO (See Comments)
Has Employee reached ***Maximum Medical Improvement*** (MMI)? ___ YES ___ NO When? _____

Can Employee work a normal shift: ____YES ____NO If NO, How many hours?_____

PHYSICAL EVALUATION FOR TRANSITIONAL WORK ASSIGNMENT

COMPLETE WHEN EMPLOYEE IS RESTRICTED FROM NORMAL WORK DUTIES (8 hour day)

(Mark the box preceding each activity, which **CAN BE safely and effectively performed** by the above named employee)

_____ Lifting & Carrying - Over 80lbs
_____ Lifting, up to 80lbs
_____ Lifting, up to 60lbs
_____ Lifting, up to 40lbs
_____ Lifting, up to 20lbs
_____ Lifting, under 20lbs
_____ Carrying, up to 80lbs
_____ Carrying, up to 60lbs
_____ Carrying, up to 40lbs
_____ Carrying, up to 20lbs
_____ Carrying, under 20lbs
_____ Use of fingers
_____ Use of hands & Arms
_____ Walking (_____ Hours)
_____ Standing (_____ Hours)
_____ Sitting (_____ Hours)
_____ Kneeling (_____ Hours)
_____ Repeated bending (_____ Hours)
_____ Pushing (_____ Hours)
_____ Pulling (_____ Hours)
_____ Twisting
_____ Climbing, use of arms and legs
_____ Use of both legs
_____ Can wear respirator
_____ Operation of moving equipment
_____ Operation of school bus
_____ Can work in Confined Space
_____ Ability for rapid mental & eye cord.
_____ Use of both eyes
_____ Hearing without aid
_____ Keep affected area clean & dry
_____ Specific Visual Requirements
_____ Specific Hearing Requirements
_____ Stooping (_____ Hours)

LENGHT OF RESTRICTIONS: 0 - 1 WEEK_____ 2 - 4 Weeks____ 6 - 8 Weeks____ 8 - 12 Weeks____

COMMENTS & MEDICATIONS PRESCRIBED:

Clinic/Hospital Address and Phone No.: _____

Physician Name (Print): _____
Signature:_____

FOLLOW UP CARE:

Physician Appointment scheduled for Date: _____ Time: _____
Scheduled therapy for Date: _____ Time: _____
Referral To: _____ Date: _____ Time: _____ PH:( )_____

RETURN THIS FORM TO:

Supervisor at school and copy school district Risk Manager for filing, FAX copy to: ( )_____

Safety Manager, PAEC 753 West blvd. Chipley, Fl 32428 FAX: (850)-638-6109

If more room is required write on the back of this form.