

NON WORK RELATED INJURY OR ILLNESS

Date: _____

Employee's Name: _____

Nature of illness or injury: _____

if surgery - type _____

date _____

Dates of incapacitation from work: _____ to _____

dates if hospitalized- _____ to _____

Date to return to work: _____

Work status: Full duty _____ or light duty _____

If light Duty:

(a) limitations - (i.e. lifting in numbers of pounds, sitting, bending, standing, work above shoulder, limit of working hours including overtime.) _____

(b) expected duration of restrictions _____

Other remarks: _____

Physician's name: _____

Address: _____

Telephone number: _____

Signature: _____

For questions or more information please feel free to call the Occupational Health Nurse Administrator at (515)283-7543

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