



County of Trinity NOTICE TO PHYSICIAN

Employee Instructions: Take this form to your physician and request he/she fill out completely. Please return to the Personnel office for clearance upon returning to work.

Employee Name _____ Date _____

Our employees are our most valuable asset. Our goal is to provide modified work whenever possible.

To Physician: Trinity County has a temporary Modified Duty Return to Work Program for injuries/illnesses. Please comment on any restrictions for this employee in order that we may accommodate them appropriately. Temporary modified duty is evaluated at each visit for improvement of the employee's symptoms.

First Visit Follow-up visit Date of next scheduled visit _____

Work Restrictions:

- NONE -Released to full duty on _____
- Released with restrictions noted below in "Restrictions" section
- Continue previous restrictions Change previous restrictions (complete below)
- Off work until _____ - State physical restrictions why employee cannot work in any capacity:

RESTRICTIONS Please check appropriate box(es)

	0 hrs.	1-2 hrs	3-5 hrs	6-8 hrs	8-10 hrs	10-12 hrs
Operating vehicles / Moving equipment						
Standing						
Walking: level ground / sloping ground						
Sitting						
Bending, stooping, squatting						
Pushing, Pulling, Twisting						
Climbing / ladders / working at heights						
Lifting up to maximum _____ lbs.						
Typing / Keyboard work						

- Limited use of **Left:** hand leg arm foot **Right:** hand leg arm foot
- Restricted head movement / rotation: _____
- Other, please specify: _____
- _____
- Medication effects which could impair performance (including driving): _____

Physician Name (print) _____ Phone No. _____

Physician Signature _____ Date _____