



Section 1 - Supervisor

Complete Section 1 and Send to the Physician with a description of work duties. Other medical documentation identifying a release to work with: (1) Applicable limitations/restrictions **AND** (2) an ending/reassessment of limitations/restrictions date or Insurer Activity Prescription form (APF)(L&I form number F242-385-000) may be substituted for this document.

Employee Name		Org. Code	Position Title
Supervisor Name		Telephone	Office Address
Date of Injury/Illness	Claim Number (if applicable)		

Section 2 -Physician's Report

Completion of Section 2 of this form will provide the Department of Transportation with information necessary to assist the employee in making a successful recovery and return to full job duties. Please return the forms to the Supervisor / Safety Officer.

This certifies that _____ has been under my care since _____

Date of Last Examination	Date of Next Examination	Est. Date of Medical Treatment Completion
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Will Medication Restrict Driving, etc.?

- If employee **can** work regular duties, go to section 3
 The employee **cannot** work regular duties
 The employee can work modified duty

1. Please review the Job Description and Essential Job Functions. Please identify, in as specific terms as you can, any job-related limitations caused by an injury or illness. **(Do not identify the injury or illness)**

2. Please list any modifications that would enable the employee to perform the essential functions that were impacted by the limitations as stated above.

3. Please list any job related limitation(s) to performing the essential functions caused by or associated with the effects of medications. **(Do not list medications)**

Section 2 -Physician's Report (continued)

4. Does the employee pose any safety risk to themselves or others in performing these duties? e.g. communicable diseases or impairments that may affect independent judgments? **(Do not identify the injury or illness.)**

5. Describe the modifications that could be made to reduce those safety risk without identifying a specific prognosis.

6. In your opinion, what is the duration of any limitation.

Section 3 - Signature

Print Physician's Name	Physician's Signature	Date
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I authorize my health care provider to complete and forward this medical questionnaire to the Washington State Department of Transportation.

Employee's Signature	Date
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Section 4 - Supervisor's Return to Work Plan

Can accommodate until date: _____ Cannot accommodate

If unable to accommodate, indicate reason:

Section 5 - Approval Signatures

Employee	Date
Immediate Supervisor	Date
Safety Officer	Date