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_____