

BRAND

This form must be completed to enable the claimant to return to work

Dear Physician:

We are willing to modify the injured worker's job to meet their medical or physical limitations. When necessary, transitional work assignments may also be available. Please be specific as to the injured worker's limitations so we may take the appropriate action. Thank you!

Employee's Name _____

Date of Injury / Illness _____

Physician's Findings and Recommendations:

Is the employee authorized to return to work? Date authorized to return: _____

_____ Yes, with no restrictions

_____ Yes, with the following medical or physical restrictions:

Anticipated date restrictions may be removed? _____

_____ No, Employee is unable to return to work because:

Is the injured employee's time of loss the direct result of the work-related injury?

_____ If yes, estimated number of disabling days: _____

_____ No

Is further treatment necessary?

_____ Yes. Next follow-up treatment: _____

Name of treating Physician _____ Phone # _____

Signature _____ Date _____

THIS PART FOR EMPLOYER ADMINISTRATION

Actual return to work date: _____

Supervisor's Name _____ Date _____

Keep copy in EE file & fax a copy to Brand Benefits at 314/985-0257 or email: benefits@beis.com