CITY OF WATERTOWN
MEDICAL SERVICE FORM

Name of Injured Employee:	Date of Injury:
Nature of Injury:	

The above named employee has reported an injury occurred while at work for the City of Watertown.

Please forward all bills to the City of Watertown's Workman's Compensation insurance carrier at:

United Heartland, Inc.
PO Box 40790
Lansing, MI 48901-7990
Fax: (262) 787-7743

Please reference policy number #090003112

The City of Watertown is committed to preventing workplace injuries, controlling injuries that do occur, and providing modified duties after an injury. The City offers many types of alternative work and/or transitional work assignments which allow an injured employee to work within their medical restrictions. Our belief is that it is in the best interest of the City of Watertown and our employees to return to work as soon as an employee is physically able. Working together with the physician, injured employees can heal and return more quickly to productive employment.

On the other side is a "Physicians Return to Work Recommendations" form to list any applicable medical restrictions. Please complete this form and give it to the employee. After treatment, the employee should return this form the Office of the City Clerk/Treasurer.

If you have questions regarding this injury or alternative duties available, please contact me.

Thank You,

Lisa Trebatoski, Deputy Clerk/Treasurer
City of Watertown
106 Jones Street
PO Box 477
Watertown, WI 53094-0477
Phone: (920) 262-4006
Fax: (920) 262-4016
E-mail: lisat@cityofwatertown.org

ATTENDING PHYSICIAN'S
RETURN TO WORK RECOMMENDATION RECORD

Patient Name (Last) (First) (Middle)	Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis and brief explanation of condition:

I saw and treated this patient on _____ (Date) and based on the above description of the patient's current medical problem:

1. ☐ Recommend his/her return to work with no limitations on _____ (Date).
2. ☐ He/she may return to work on _____ (Date) with the following limitations:

CHECK ONLY AS RELATES TO ABOVE CONDITION

☐ SEDENTARY WORK: Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ LIGHT WORK: Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ LIGHT MEDIUM WORK: Lifting 30 pounds maximum with frequent lifting and/or carry of objects weighing up to 20 pounds.

☐ MEDIUM WORK: Lifting 50 pounds maximum with frequent lifting and/or carry of objects weighing up to 25 pounds.

☐ LIGHT HEAVY WORK: Lifting 75 pounds maximum with frequent lifting and/or carry of objects weighing up to 40 pounds.

☐ HEAVY WORK: Lifting 100 pounds maximum with frequent lifting and/or carry of objects weighing up to 50 pounds.

☐ DRY WORK: Work that would avoid moisture on injured area.

1. In an 8 hour work day patient may:
   a. Stand/walk
      ☐ None ☐ 4-6 Hours
      ☐ 1-4 Hours ☐ 6-8 Hours
   b. Sit
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
   c. Drive
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
2. Patient may use hand(s) for repetitive:
   ☐ Single grasping ☐ Pushing & Pulling
   ☐ Fine manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐ Yes ☐ No
4. Patient may:

	Not at all	Occasionally	Frequently
a. Bend	☐	☐	☐
b. Twist	☐	☐	☐
c. Squat	☐	☐	☐
d. Climb	☐	☐	☐
e. Reach	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS:

3. ☐ These restrictions are in effect until _____ (Date) or until patient is reevaluated on _____ (Date).
4. ☐ He/she is totally incapacitated at this time. The patient will be reevaluated on _____ (Date).
5. ☐ Referred to: ☐ None ☐ Return Here ☐ Other Physician_____ (Name) ☐ Consultant_____ (Name)

Physician's Signature:	Date:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician or practitioner identified on this form to release and disclose to the City of Watertown such health records and information concerning my medical condition as is necessary to support my request for absence from work and/or any additional benefits my employer may provide.

Patient's Signature:	Date: