QUESTAR III

ATTENDING PHYSICIAN'S STATEMENT

DIRECTIONS TO EMPLOYEE:

This form is to be completed in full by employee and attending physician. Completed form is to be returned to the Questar III Human Resources Office by your physician.

TO BE COMPLETED BY EMPLOYEE:

Employee's name: _____

Assignment/location: _____

Date of injury or illness: _____

Nature of injury or illness: _____

If injury, where and how did it happen: _____

I hereby authorize my physician to release to the Rensselaer-Columbia-Greene BOCES the information requested on this form._____

_____ _____

Employee signature Date

TO BE COMPLETED AND SUBMITTED BY PHYSICIAN:

Date first consulted by patient: _____ Date of next appointment: _____

Pregnancy: _____Yes _____ No Expected delivery date: _____

Diagnosis or concurrent condition of patient: _____

Date injury or symptoms first appeared: _____

Is condition related to employment: _____ Yes _____ No Expected treatment duration: _____

Date patient to return to work: _____

Patient was confined to hospital from: _____to _____

Patient was confined to house from: _____to _____

Patient was totally disable (unable to work) from: _____ to_____

Patient was partially disabled from: _____ to _____

May patient continue and/or resume normal duties without any limitations: _____Yes _____ No

If no, please explain: _____

Remarks: (any other comments regarding partial disability, work limitations, medications, etc.)

_____

Physician's name: _____

Address: _____

Business telephone: _____ Date: _____

Physician's signature: _____

TO BE COMPLETED BY PERSONNEL OFFICE:

Date Employee last worked: _____ First full working day absent: _____

W/C claim filed: _____ Date return to work: _____

Remarks: _____

Received by: _____ Approved by: _____

Name and Date Name and Date