KAISER PERMANENTE

VISIT VERIFICATION/FAMILY LEAVE Health Care Provider Certification

Patient Name Identification

Anderson Tiffany
7897964

IMPRINT AREA

THE ABOVE NAMED PERSON:

☑ Was seen at this office on: 12/4/06. ☐ Has been given telephone advice on: _____

☑ Has been ill and unable to attend work/school/physical education 12/4/06. through 12/7/06.

☐ **States** he/she has been ill and unable to attend work/school/physical education _____ through _____

☐ **Can return to full duties with NO RESTRICTIONS on** 12/8/06. **OR**

☐ **Can participate in a modified work program starting** _____ **and continuing to** _____

(Please note: If modified work is not available, this patient is then unable to work for this time period.)

☐ Restrictions: _____ hours per day _____ hours per week

BASED ON AN 8-HOUR DAY EMPLOYEE CAN:

stand/walk	_____ minutes per hour	_____ total hours	☐ no restrictions
sit	_____ minutes per hour	_____ total hours	☐ no restrictions
drive	_____ minutes per hour	_____ total hours	☐ no restrictions

LIFT/CARRY (Occasionally = up to 1/3 workday. Frequently = up to 2/3 workday):

0-10 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
11-25 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
26-40 lbs.	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

Can lift/carry up to _____ **lbs.**

EMPLOYEE IS ABLE TO:

bend	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
squat	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
kneel	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
climb	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
reach above shoulders	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions
perform repetitive hand motions	☐ not at all	☐ occasionally	☐ frequently	☐ no restrictions

ASSISTIVE DEVICES? (e.g., cast, brace, crutches) _____

RESTRICTIONS: _____

OTHER: _____

TREATMENT PLAN: _____

☐ Medication effects which could impair performance: _____

☐ Physical therapy required. Frequency: _____

NOTE: If patient is **industrial, physician** signature is **REQUIRED.**

SIGNATURE AND TITLE		DATE
Jade Smith MD		12/4/06.
NAME (PRINT)	LOCATION/ADDRESS	PHONE
JASMITH		

98082 (REV.2-03) **DISTRIBUTION:** WHITE = CHART • PINK & CANARY = PATIENT