

VISIT VERIFICATION/FAMILY LEAVE Health Care Provider Certification

Patient Name Identification

Vist in the same				IMPRINT AREA		
	TOTAL WIND TOTAL	To the Core	347		عرا أوركم	
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/	14/06	□ Hankana ak	talaabaaa ad	dee eeu		
Was seen at this office on:		Has been given telephone adv		through 12/7./06.		
Has been ill and unable to atten				through		
States he/she has been ill and	unable to attend work/school/p	hysical education		through		
Can return to full duties with	NO RESTRICTIONS on	18/06.			OI	
☐ Can participate in a modified	work program starting	, plan Na	and c	ontinuing to	- m	
(Please note: If modified work	is not available, this patient	is then unable to wor	rk for this time p	eriod.)		
Restrictions:	hours per day	hours	per week			
BASED ON AN 8-HOUR DAY EMP	PLOYEE CAN:					
stand/walk	minutes per hour	total hours		☐ no restrictions		
	A TRANSPORT OF THE PARTY OF THE			□ no restrictions		
sit	minutes per hour	total hours		no restrictions	* 1	
drive	minutes per hour		nours	☐ no restrictions	-	
LIFT/CARRY (Occasionally = up to			☐ frequently	☐ no restrictions		
0-10 lbs. 11-25 lbs.	□ not at all	☐ occasionally ☐ 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	à.	
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:						
		1				
TREATMENT PLAN:						
☐ Medication effects which could	impair performance:					
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Dhysical thereny required From						
Physical therapy required. Free	quericy.					
	"		less of the less	FOLUBED		
SIGNATURE AND TITLE	OTE: If patient is indus	strial, physician s	signature is R		ATE/	
Jacle 11 12				1	2/4/06	
NAME (PRINT)	LOCATION/ADDRESS		2 4	P	HONE	
98082 (REV.2-03)	DISTRIBUT	TION: WHITE = CHART . P	PINK & CANARY = P	ATIENT	a vinda kalak je s	