



ATTENDING PHYSICIAN'S REPORT

Employee Name _____ SS# _____

Physician _____ Date _____

I hereby request medical treatment and authorize the physician(s) to release to my employer or its representatives, all information, opinions, conclusions found as a result of his/her evaluation and/or treatment of my injury.

Employee Signature _____ Date _____

Instructions to attending physician: Please complete this form and return to employee. Note that we have extensive modified duty available. Be sure to give us any specific limitations our employee may have, and we will gladly accommodate.

Diagnosis: _____

Treatment: _____

Recheck? _____

Please note that if employee needs referral to a specialist, you must contact our office prior to any referrals.

Work Status Report

_____ Regular duty / no restrictions

_____ Modified duty / as below (duration: _____ days)

_____ No work (duration: _____ days) **Please call our office to discuss the availability of modified duty prior to placing anyone on a "No work" restriction.

Modified duty restrictions:

_____ No climbing

_____ No pushing or pulling

_____ No standing/walking

_____ No reaching above shoulders

_____ No bending/stooping

_____ No operating heavy machinery

_____ No lifting over _____ pounds

_____ Other restrictions: _____

Physician Signature _____ Date _____

Sumter County Schools
Attn: Human Resource
100 Learning Lane
229-931-8500

Underwriter: Georgia Administrative
1775 Spectrum Drive, Suite 100
Lawrenceville, GA 30043
800-421-0710 / FAX 770-963-5754