MEDICAL STATEMENT FORM

Name of Employee Requesting Accommodation: (Last, First, Middle Name)	
Employee ID#	Best phone # to call:
Authorization to Release Information: I hereby authorize the undersigned physician to release any and all information acquired in the course of my examination and treatment for the purpose of consideration. _________________________________ _____________________________ Employee's signature Date	
Brief description of employee's duties: (completed by supervisor). Attach additional information if necessary.	

To be completed by the attending physician:

HISTORY

When did the patient first seek treatment for the limitation due to pregnancy _______________(date)

To your knowledge, has patient ever had the same or similar condition ☐ Yes ☐ No

If yes, please describe: ____

____

DIAGNOSIS

Give a complete narrative of the nature and extent of the present illness/injury which is creating the need for an accommodation:

TREATMENT

Date of first visit/treatment: _______________Frequency of visits: (Weekly, monthly, other): __________

When did you last examine the patient ____________________________________ (date)

Give a brief description of the continuing treatments:

PROGNOSIS

If there are no further complications, what is the minimum time to return to work? __________________

Approximate return date: ________________Would there be a possibility of this patient returning to work on a part-time basis with duties altered within reason to better fit their needs? ☐ Yes ☐ No

Explain limitations:

Clinic Name:	Attending Physician's Signature:
Telephone:	Date: