New Mexico State Personnel Office

Leave Management

DOCTOR VISIT/MODIFIED WORK ASSIGNMENT

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO HIS/HER EMPLOYER AT THE CONCLUSION OF **EACH AND EVERY** DOCTOR VISIT.

DATE_____ EMPLOYEE NAME_____

DOCTOR _____ EMPLOYEE AGENCY/ID #_____

1. DIAGNOSIS:_____
2. WAS EMPLOYEE RELEASED TODAY?_____
3. X-RAY(S) TODAY?_____
4. MEDICATION PRESCRIBED AND/OR CONTINUED?_____
5. CAN EMPLOYEE RETURN TO NORMAL DUTY AT THIS TIME?_____
6. IF YES, HAS THE EMPLOYEE REACHED MMI?_____
7. IF NO, CAN EMPLOYEE RETURN TO WORK ON A LIMITED/RESTRICTED BASIS?_____
8. WHAT RESTRICTIONS?

   NO REACHING ABOVE SHOULDER_____

   NO PUSHING/PULLING_____

   NO CLIMBING OF STAIRS OR LADDER?_____

   NO OPERATION OF MACHINERY_____

   NO LIFTING OVER_____

   NO REPETITIVE WAIST BENDING_____

   NO KNEELING/SQUATTING_____

   LIMITED USE OF_____

9. HOW LONG WILL RESTRICTIONS LAST: UNTIL NEXT VISIT_____OTHER DATE_____

   WHEN IS NEXT VISIT SCHEDULED?_____

10. OTHER COMMENTS_____

ATTENDING DOCTOR_____

MODIFIED WORK ASSIGNMENT

I,_____have read the restrictions and have discussed said restrictions with my supervisor/employer.

I understand the nature of the restrictions and further understand that any violations of said restrictions may cause aggravation or further, injury. I also understand and will comply with the rules or orders noted as a condition of employment on a modified work assignment.

_____

Employees Signature Date_____

_____

Immediate Supervisor Date_____