REPORT OF WORK ABILITY

EMPLOYEE:	*1. PLEASE HAVE EACH HEALTHCARE CLINICIAN COMPLETE THIS FORM AT EACH VISIT TO THE CLINICIAN:* *2. PLEASE PROVIDE A COPY OF THE COMPLETED FORM TO YOUR SUPERVISOR AFTER EACH VISIT*
CLINICIAN:	*PLEASE COMPLETE, SIGN AND FAX THIS FORM TO EMPLOYMENT SERVICES AT:*

EMPLOYEE INFORMATION

Last Name ________________________________ First Name _____________________________ Middle Initial_____

Employee ID# ______________ Date of Birth ______________ Date of Injury/Illness ______________ Job Title/Description ____________________ Phone ___________________

Employer_________________________________ Supervisor or Contact_____________________ Employer Phone_______________

Worker's Compensation Administrator/Billing Information **Claim Number** ______________________________
CCMSI, P.O. Box 30870, Albuquerque, NM 87190 505-837-8700

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.
Patient Signature:____ Date: _____________________________________

TREATING PROVIDER'S EVALUATION-COMPLETE IN FULL FOR EACH VISIT

Treatment Date_______________________ For: ☐ Initial Treatment ☐ Follow-up Appointment

Nature of Visit: ☐ Work Related ☐ Not Work Related ☐ Unknown

Describe Circumstances of the Injury/Illness:____
Diagnosis:____
Treatment:____

Medication Prescribed Could Cause Drowsiness or Impair Ability and/or Operate Heavy Equipment: ☐ Yes ☐ No

Maximum Medical Improvement Reached: ☐ Yes ☐ No Date of MMI: ___________________________
Impairment Rating (PPD) if applicable: ____
Referral/Consult: ____
Next Appointment: Date: ____________________ Time: __________________ Doctor: ________________________________

EMPLOYEE CAPABILITIES

Employee is released from care and has no restrictions.

☐ **May return to work with no restrictions:** ☐ Immediately, or ☐ Beginning ____________________________

☐ Injury will result in loss of time from work: from _______________________ through _________________________

☐ May return to work with the following restrictions:____
from ______________ through _____________

☐ Estimated Return to Full Duty is: _____/_____/_____

TREATING PROVIDER

Provider Name (please print) ______________________________________Clinic Name _______________________________________

Provider Signature ____Clinic Address ______________________________________