Fermilab

ORIGINAL copy to your supervisor immediately after leaving the medical office.

ISN_____ **INJURY/ILLNESS EVALUATION FORM-5**

To: _____Div/Sec_____Supv MS_____

From: **Medical**

After examination and evaluation of_____ID#_____,
I have determined that he/she is able to:

( ) Returned to work with no limitations.
( ) Returned to work with the following limitations until_____:
( ) Unable to perform any work (sent home.)

The individual is returned to work and will be re-evaluated on_____."

The above issues are/were due to Occupational Injury/Illness: **( )** Yes **( )** No **( )** Claim Pending

Medical signature _____ Date _____

FOR THE SUPERVISOR:
( ) ***Complete sections below, and return as directed.***
( ) ***For Supervisor's records only. Do not return.***
Routine Job Functions = those work activities that the employee regularly performs at least once per week.

( ) The above limitations do not restrict the employee's ability to perform his/her routine job functions. The employee will not be assigned any non-routine tasks which would conflict with the limitations above.

( ) The limitations noted above prevent the employee from performing some of his/her routine job functions, but the employee's job will be modified to accommodate the limitations noted above;

( ) The employee's job cannot be modified to accommodate the limitations noted above, but he/she will be given a different job assignment subject to the above limitations until such time as the limitations are removed; or revised.

( ) The employee cannot perform any of his/her job duties with the above limitations and a change in job assignments is not available. **(*Please contact the Medical Office to discuss options*.)**

I have reviewed and understand the recommendations as listed above.

Supervisor signature/ID #_____Date _____

FOR THE EMPLOYEE: I have reviewed and understand the information noted above. I have discussed this information with the Laboratory's physician and my supervisor. I agree to make myself available for a re-evaluation on the date noted above. I will also notify the Medical Office if my condition improves before my next scheduled appointment and understand that if I do not comply with my restrictions, disciplinary action may result.

Employee signature_____Date _____

FOR THE SAFETY OFFICER: I have reviewed the above information.

Division Safety Officer signature/ID #_____Date _____
(or designee)

This original form with ALL signatures must be returned to the *Medical Office, MS 204, within 5 working days.*
If there are any questions, please contact the Medical Office at extension 3232.

( ) ORIGINAL ( ) COPY Revised: 9/18

Injury Incident Involvement Form

Name: _____ I.D.#: _____ Date: _____

ON _____ [ ] I WITNESSED **or** [ ] WAS INVOLVED IN **an** [ ] INCIDENT or [ ] NEAR MISS
(date)

Time of injury: _____ Employee work start time: _____

Location of incident: _____Witness: _____

EMPLOYEE'S STATEMENT OF THE INCIDENT/NEAR MISS EVENTS

By placing my signature below I hereby certify that the information provided on this Form 5 is true and accurate.

_____
(signature) (date)