



ISN: _____

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

INJURY/ILLNESS EVALUATION FORM-5

To: _____ Div/Sec _____ Supv MS _____

From: Medical Office:

After examination and evaluation of _____ ID# _____, I have determined that he/she is

- 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 Supervisors 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.

Senior 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: February 2015

