

Mount Holyoke College
INITIAL/SUPPLEMENTAL MEDICAL TREATMENT FORM

0002

EMPLOYEE: _____ DATE OF INJURY: _____
 DATE OF EXAM: _____ TIME ARRIVED: _____
 DESCRIPTION OF ACCIDENT: _____ TIME DEPARTED: _____
 INITIAL COMPLAINT/CONTINUED COMPLAINT: _____

DIAGNOSIS: _____

- | | |
|---|--|
| <input type="checkbox"/> Direct result of single accident | <input type="checkbox"/> Cumulative condition |
| <input type="checkbox"/> Chronic/recurring disease | <input type="checkbox"/> Toxic/hazardous substance |

TREATMENT/MEDICATION: _____

- EMPLOYEE CAN RESUME REGULAR WORK IMMEDIATELY
 EMPLOYEE CAN RESUME ALTERNATE WORK IMMEDIATELY

WHAT EMPLOYEE CAN DO:

<u>Activity</u>	<u>Duration</u>	<u>Activity</u>	<u>Duration</u>
Walking	_____	Reaching	_____
Standing	_____	Stooping	_____
Sitting	_____	Climbing	_____
Bending	_____	Driving	_____
Answering phone	_____		

- | | |
|--|--|
| <input type="checkbox"/> Sitting Work Only | <input type="checkbox"/> Lifting up to: _____ 5 lbs. |
| <input type="checkbox"/> Sit and Stand as Needed | _____ 10 lbs. |
| <input type="checkbox"/> No Work | _____ 15 lbs. |
| <input type="checkbox"/> Dry Work | _____ 20 lbs. |
| <input type="checkbox"/> As much as splint/bandage permits | _____ 25 lbs. |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Avoid overhead reaching |

IF EMPLOYEE IS UNABLE TO RETURN TO WORK IMMEDIATELY

WHEN CAN EMPLOYEE RETURN TO ALTERNATE DUTY: _____

WHEN CAN EMPLOYEE RESUME REGULAR WORK: _____

NEXT FOLLOW-UP APPOINTMENT: _____

PROVIDER SIGNATURE: _____

DOCTOR'S ADDRESS: _____

EMPLOYEE RELEASE

I hereby authorize the release of any and all requested medical information concerning my injury or illness of _____ to my employer and its authorized representatives. A photocopy of this release shall serve and be as valid as the original. This release shall be valid until withdrawn by me in writing.

EMPLOYEE SIGNATURE _____ Date: _____