**Medical Provider Signature Page**

(please address one of the four areas below)

🞎 I agree that the above name injured worker can perform the activities described in this job analysis and can return to work from a mental health standpoint.

 Release date, ONLY if different from today’s date. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 I agree the injured worker can perform the described job but only with modifications as described below.

|  |
| --- |
|  Comments: |

 Modifications are needed on a (permanent 🞎) or (temporary 🞎) basis.

* The above-named injured worker ***temporarily*** cannot perform this job based on:

|  |
| --- |
| Mental Health Limitations & Findings: |

|  |  |
| --- | --- |
| **Anticipated release date:** |  |
| **Treatment plan:** |  |

* The above named injured worker is ***permanently*** restricted from performing the physical activities described in this job analysis based on:

|  |
| --- |
| Mental Health Limitations & Findings: |

* Restriction based on accepted conditions on claim.
* Restriction based on unaccepted conditions on claim.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Specialty