

CITY OF CHICO – PROVIDER LETTER

☐ Non-Industrial☐ Industrial

Employees of the City of Chico are required to submit a letter to his/her department following each doctor's visit in workers compensation cases and in accordance with the time frame specified in the Administrative Procedure & Policy relating to Sick Leave Accrual Schedules for personal illness or injury (AP&P 13-21).

EMPLOYEE/INJURY INFORMATION

Employee Name:	Date of Injury:
Date of Exam:	Date of Next Appointment:
Prognosis:	Referred To:
Physical Therapy Ordered: ☐ No ☐ Yes	Surgery Scheduled: ☐ No ☐ Yes, Date:

WORK STATUS

☐ Released to full duty with <u>no restrictions</u> . <i>Effective Date:</i>
☐ Restricted/modified duty. <i>Effective Date:</i> _____ <i>Estimated return to full duty:</i> _____

WORK RESTRICTIONS/FUNCTIONAL CAPACITY

Maximum hours employee can perform each activity per day

Activity	No Restriction	6 Hours	4 Hours	2 Hours	1 Hour	Precluded	Comments
Sitting							
Standing							
Walking							
Squatting/Kneeling							
Crawling							
Laying on Back/Stomach							
Bending							
Twisting							
Reaching/Pushing/Pulling							R / L / Bilateral
Grasping							
Fine Manipulation							
Keyboard Use/Typing							
Lifting							May not lift at a height of <u>waist / shoulder / overhead</u> (check) more than _____ lbs.
Carrying							May not carry at a height of <u>waist / shoulder / overhead</u> (check) more than _____ lbs.
Driving							
Commercial Driving							

Does employee need periodic rest breaks?	☐ Yes ☐ No
Can employee have contact with the public?	☐ Yes ☐ No
Is employee on any medication that affects work ability (driving, operating machinery)?	☐ Yes ☐ No
Can employee work in extreme temperatures?	☐ Yes ☐ No
Can employee work at extreme heights?	☐ Yes ☐ No

Additional restrictions/comments:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my knowledge and belief that I have not violated California Labor Code Section 139.3

Physician's Name:	Facility Phone Number:	Facility Fax Number:
Facility Address:		
Physician Signature:		Date: