

CITY OF CHICO – PHYSICIAN 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 (Circle)
Grasping							
Fine Manipulation							
Keyboard Use/Typing							
Lifting							May not lift at a height of <u>waist / shoulder / overhead</u> (circle) more than _____ lbs.
Carrying							May not carry at a height of <u>waist / shoulder / overhead</u> (circle) 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:	