

OBERLIN COLLEGE PHYSICIAN'S STATEMENT BWC Claim # _____

Under the medical leave policy for Oberlin College, medically disabled employees may be issued a conditional or approved leave of absence based in part on information received from the attending physician or a company-appointed doctor.

It shall be the responsibility of each employee to see that such information is made available on a timely basis and updated as required. Any delay in this information may cause a disruption of your Oberlin College paid benefits.

SECTION I (To Be Completed By The Employee)

AUTHORIZATION TO HOSPITAL, DOCTOR OR OTHER INSURANCE COMPANY

I request and authorize you to furnish Oberlin College, or its authorized representative, or to permit the representative to obtain a statement or review or make or obtain a copy, in whole or in part, of any or all information with respect to any illness or injury including but not limited to medical history, diagnosis, consultations, examinations, prescriptions, treatments, operative procedures, x-rays, and pathological findings or tests you may have concerning me. This information is to include alcohol abuse, substance abuse or mental health records. A photocopy of this authorization shall be as valid as the original.

Date Patient Signature Print Name

SECTION II (To Be Completed By Physician)

Patient Name: _____

1. Was disability due to occupational accident or occupational sickness? _____
If so, please give full particulars _____

Has this Injury been filed with Ohio's Workers' Compensation? _____ Yes _____ No

2. Date of illness (first symptom) , injury (accident) or pregnancy _____ 3. Date first consulted you for this condition: _____

4. Has patient ever had same or similar symptoms? _____ Yes _____ No

5. If an emergency, check here _____

6. Is this an aggravation of a pre-existing condition? _____ Yes _____ No

7. If pre-existing when was diagnosis first determined? _____

8. Name of referring physician or other source (e.g. public agency) _____

9. Diagnosis (ICD-9 codes) or nature of illness or injury
1. _____
2. _____
3. _____
4. _____

10. If surgery performed, describe operation _____

11. Give dates on which you attended patient: Date of surgery _____
At hospital _____
At office _____

12. Was patient confined in a hospital? _____ Date Admitted _____ Date Discharged _____
Name & address of hospital _____

13. Dates of Disability due to injury/disease? From _____ To _____

14. Date of next exam or treatment _____

OBERLIN COLLEGE OCCUPATIONAL RESTRICTIONS

**Please review Patient's job description when listing work restrictions if any. (Description provided by Patient)
Be aware that any restrictions MAY prohibit the Patient from returning to working.**

15. In an eight-hour workday, the client can (circle a capacity for each activity)

Sit	1	2	3	4	5	6	7	8	hours
Stand	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

16. Patient is able to:

	<u>Not at All</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
Bend/Stoop	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Reach Above Shoulder Level	_____	_____	_____	_____
Kneel	_____	_____	_____	_____
Push/Pull	_____	_____	_____	_____

17. Patient can carry/lift **unassisted**:

	<u>Not at All</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
Up to 10 pounds	_____	_____	_____	_____
11 - 20 pounds	_____	_____	_____	_____
21 - 30 pounds	_____	_____	_____	_____
31 - 40 pounds	_____	_____	_____	_____
41 - 50 pounds	_____	_____	_____	_____
51 - 60 pounds	_____	_____	_____	_____
*Can Patient carry/lift with assistance:				
> 61 up to 100 pounds	_____	_____	_____	_____

18. Given the Patient's condition and/or medication, can he/she operate a moving vehicle and/or power equipment safely and responsibly? _____ Yes _____ No

19. Patient can use hands for repetitive action such as:

Simple Grasping	Right hand	___ Yes ___ No	Left hand	___ Yes ___ No
Firm Grasping	Right hand	___ Yes ___ No	Left hand	___ Yes ___ No
Fine Manipulating	Right hand	___ Yes ___ No	Left hand	___ Yes ___ No

20. Patient can use head and neck in:

Static Position	___ Yes	___ No
Frequent Flexing	___ Yes	___ No
Frequent Rotating	___ Yes	___ No

21. Restriction of activities, such as being around moving equipment or driving:

22. **Date Patient able to return to work with above restrictions** _____ **Estimated** **Actual**

23. **Date Patient able to return to work without restrictions** _____ **Estimated** **Actual**

24. Physician or provider's name, address and telephone number:

25. Physician's Phone Number () _____

26. Physician's Provider Number _____

27. Physician's Printed Name _____

28. Signature of Physician: _____ Date _____
