CAPITAL DISTRICT TRANSPORTATION AUTHORITY

MEDICAL STATEMENT/UPDATE AND RETURN-TO-WORK FORM

TO BE COMPLETED BY EMPLOYEE:

EMPLOYEE ID# _____ EMPLOYEE NAME _____

DIVISION _____ DEPARTMENT _____

DATE OF INJURY/ILLNESS _____

IF INJURED, WHERE AND HOW DID IT HAPPEN

ARE YOU CURRENTLY RECEIVING SOCIAL SECURITY DISABILITY BENEFITS? YES____ N

I hereby authorize any hospital, physician, employee insurance company or other organization to release to CDTA or its authorized representative any and all information they may have with respect to any sickness or injury that is currently preventing me from performing the full function of my job. This includes past and present medical history, diagnosis, consultations, treatments, operative procedures, xrays and pathological findings relating to my current illness or injury. I agree that a photostat copy of this authorization shall be considered as effective as the original and that all of the information that I have provided is truthful and to the best of my knowledge.

EMPLOYEE SIGNATURE _____ DATE _____

TO BE COMPLETED BY PHYSICIAN:

DATE FIRST CONSULTED BY PATIENT: _____

DATE OF LAST APPOINTMENT: _____

DATE OF NEXT APPOINTMENT:

DIAGNOSIS OR CURRENT CONDITION OF PATIENT	**(PLEASE BE SPECIFIC)**	

WHAT IS THE REGIMINE OF CARE? IS THIS PERSON IN PHYSICAL THERAPY OR ANOTHER TYPE OF SPECIALIZED PROGRAM DESIGNED TO HEAL HIS/HER INJURY? IF YES, WHAT IS THE PROGRAM?

IF THIS PERSON IS IN THERAPY TO HEAL HIS INJURY, WHAT IS THE SCHEDULE OF THERAPY?

WHAT IS THE EXPECTED DATE OF RETURN TO WORK FOR THIS PERSON? (MUST BE AN ANTICIPATED DATE)
____/_____/_____

IS CONDITION RELATED TO EMPLOYMENT	YES		NO		

PATIENT WAS TOTALLY DISABLED				PATIENT WAS PARTIALLY DISABLED			
FROM:		TO:		FROM:		TO:	

REMARKS: (PARTIAL DISABILITY, WORK LIMITATIONS, MEDICATIONS, COMMENTS, ETC.)

MAY PATIENT CONTINUE AND/OR RESUME NORMAL DUTIES WITHOUT ANY LIMITATIONS? YES_____ NO_____	
(IF NO, PLEASE EXPLAIN)	

DO YOU ANTICIPATE THIS PATIENT BEING ABLE TO COME BACK TO WORK AS A FULL TIME EMPLOYEE IN THE SAME POSITION THAT THEY HELD BEFORE THEIR INJURY/ILLNESS? YES_____ NO_____	
(IF NO, PLEASE EXPLAIN)	

OTHER COMMENTS:

PHYSICIAN'S NAME (print): _____ **ADDRESS:** _____

SIGNATURE: _____

Original: Human Resources