CITY OF HAMMOND
ATTENDING PHYSICIAN'S REPORT
Non-Classified Employees

MEMO TO CITY PERSONNEL: DATE: ______/_______/_______

This form must be completed and returned to the DEPARTMENT HEAD no less than two (2) calendar days after beginning an illness or injury.

TO BE COMPLETED BY THE EMPLOYEE:

DATE OF ILLNESS OR INJURY: ______/______/_______

Name: ___________________________________ Telephone: ______________________

Physical Address: ____

____ Injury Did the injury occur while on duty? Yes No

____ Illness Did the illness occur while on duty? Yes No

Doctor's Name (print): ____________________________

Doctor's Phone Number: __________________________

TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

I HAVE EXAMINED THE ABOVE NAME EMPLOYEE AND RECOMMEND:

☐ Return to Work (Full Duty): ______/______/_______

☐ Return to Work (Limited Duty): _____/_____/_______for ___________________

Restriction For Limited Duty:

☐ No Standing/Walking more than_____ Minutes/Hours at a Time with _____minutes rest between.

☐ No Use of L/R Hand/Arm for Strenuous Repetitive Activity.

☐ No Bending/Squatting/Kneeling/Crawling/Reaching with L/R Arm/Hand.(Circle)

☐ No Heights/Climbing

☐ No Lifting/Pushing/Pulling more than_____ lbs. with L/R Arm/Hand. (Circle)

☐ Cannot Return to Work Until: _____/_____/_______

Next Appointment Date: _____/_____/_____

______________________________________ ______________________________________
Physician's Signature Department Manager's Signature

Date: ______/______/_______ Date: ______/______/________