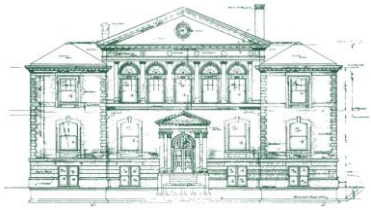

City of Bowling Green

Human Resources & Risk Management

Erin Hulsey
HR Director

David Weisbrodt
Safety & Risk Manager

Tiara Britt
HR Manager

Lori Gray
HR Manager

Kim Ives
HR Specialist

Kirsten Homer
Benefits Coordinator

Angela McCarley
Office Associate II

Theresa Hendrick
Office Associate II

MEMORANDUM

TO: Treating Physician

FR: David Weisbrodt, Safety & Risk Manager

RE: Modified Duty Assignment

It is the policy of the City of Bowling Green, when possible, to modify work assignments for a limited time period in order to assist employees who are temporarily restricted from performing their regularly assigned duties due to a work related and non-work related injury/illness.

The City's modified duty positions provide the injured employee with work assignment that meets restrictions which may have been prescribed by the employee's evaluating physician. Modified duty positions vary by City department however each department has the capability and the willingness to provide modified duty assignments that meet physician restrictions up to and including sedentary work.

When completing the employee's return-to-work statement, we ask that you please specify any restrictions and a specific time period for which the restrictions apply.

Please feel free to call me at 270-202-6776, should you have any questions or need additional information.

PLEASE SIGN AND RETURN THIS FORM ALONG WITH THE RETURN-TO-WORK STATEMENT

_____ _____

Physician's Signature Date

CITY OF BOWLING GREEN
PHYSICIAN'S REPORT OF INJURY/ILLNESS

TO BE COMPLETED BY EMPLOYER:

Employee Name: _____

Social Security #: _____ **Sex:** ☐ **Male** ☐ **Female**

Employer Contact: **David Weisbrodt** **Telephone:** **(270) 202-6776** **Fax:** **(270) 901-3162**
Theresa Hendrick **Telephone:** **(270) 393-3680** **Fax:** **(270) 901-3162**

TO BE COMPLETED BY EMPLOYEE:

I will return this form promptly to my employer. I authorize my attending physician to release any and all information acquired in the course of examination to my employer.

_____
Employee Signature

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Treatment: _____

Return to Work Statement

IMPORTANT: The return to work selection is to be completed by the physician, assuming the employee's work schedule will require them to return to work immediately.

☐ **May return to work at regular duty on** _____ **(date) with no physical limitations**

☐ **May return to work on** _____ **(date) with the following physical limitations:**

Activity	Limitations
Walking	☐ No Walking ☐ Limit Walking to: _____
Lifting	☐ No Lifting ☐ No lifting over _____ pounds. ☐ No bending/stooping/twisting ☐ No pushing/pulling over _____ pounds. ☐ Work only at chest level
Sitting	☐ Sitting job only ☐ Alternate sitting/standing
Driving	☐ No driving to or from work ☐ No driving at work ☐ No driving while on prescribed medication
Climbing	☐ No climbing
Other	☐ _____

☐ **Remain off work until** _____ **(date).**

Additional Physician Statement
Complete if applicable:

☐ **Patient has a follow-up appointment at:** _____

☐ **Patient has been referred to:** _____

☐ **Patient has reached maximum medical improvement**

Physician comments: _____

_____

_____

_____ _____
Physician Signature Date