REPORT OF WORK ABILITY

EMPLOYEE:	*1. PLEASE HAVE EACH HEALTHCARE CLINICIAN COMPLETE THIS FORM AT EACH VISIT TO THE CLINICIAN:* *2. PLEASE PROVIDE A COPY OF THE COMPLETED FORM TO YOUR SUPERVISOR AFTER EACH VISIT*
CLINICIAN:	*PLEASE COMPLETE, SIGN AND FAX THIS FORM TO EMPLOYMENT SERVICES AT:*

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial____

Employee ID# _____ Date of Birth _____ Date of Injury/Illness _____ Job Title/Description _____ Phone _____

Employer_____ Supervisor or Contact_____ Employer Phone_____

Worker's Compensation Administrator/Billing Information **Claim Number** _____
CCMSI, P.O. Box 30870, Albuquerque, NM 87190 505-837-8700

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.
Patient Signature:_____ Date: _____

TREATING PROVIDER'S EVALUATION-COMPLETE IN FULL FOR EACH VISIT

Treatment Date_____ For: ☐ Initial Treatment ☐ Follow-up Appointment

Nature of Visit: ☐ Work Related ☐ Not Work Related ☐ Unknown

Describe Circumstances of the Injury/Illness:_____
Diagnosis:_____
Treatment:_____

Medication Prescribed Could Cause Drowsiness or Impair Ability and/or Operate Heavy Equipment: ☐ Yes ☐ No

Maximum Medical Improvement Reached: ☐ Yes ☐ No Date of MMI: _____

Impairment Rating (PPD) if applicable: _____
Referral/Consult: _____
Next Appointment: Date: _____ Time: _____ Doctor: _____

EMPLOYEE CAPABILITIES

Employee is released from care and has no restrictions.

☐ **May return to work with no restrictions:** ☐ Immediately, or ☐ Beginning _____

☐ Injury will result in loss of time from work: from _____ through _____

☐ May return to work with the following restrictions:_____
from _____ through _____

☐ Estimated Return to Full Duty is: _____/_____/_____

TREATING PROVIDER

Provider Name (please print) _____Clinic Name _____

Provider Signature _____Clinic Address _____