

PHYSICIAN'S REVIEW OF TRANSITIONAL DUTY

RE: Claimant: _____

Employer: _____

Claim #: _____

Date of Injury: _____

I have reviewed the description of the alternate duty position for _____,
(claimant's name)
dated _____. My recommendation on _____'s ability to return
(date) (claimant's name)
to work in this duty position is:

Worker is able to perform the alternate duty as described.

Worker is able to perform the alternate duty with the following changes:

1. _____
2. _____
3. _____
4. _____
5. _____

Worker is unable to perform the alternate duty at this time. Estimated time for
release to this duty is _____.
(Date)

Physician Signature

Date

Physicians Name

Phone Number