Physician's Report Form

I authorize release of information concerning my current medical condition to the Company Nurse, Human Resources of I/N Tek I/N Kote; and, should the company request a fit-for-duty-exam, Memorial COH and ArcelorMittal USA Medical Department Personnel. I may ask the company nurse to fax this form to you on my behalf. The information provided is necessary to determine eligibility for disability benefits payable when I am incapacitated or unable to work even restricted duty.

Employee Name: _____ Birth Date: _____

Boundary Area:_____ Home/Cell Phone: _____

Employee/Patient Signature: _____ Date: _____

[Verbal authorization obtained: _____ Date: _____]

Completed by Physician

Physician Name: _____ **Date of Appt:** _____

Phone: _____ **Fax:**_____ **Next Appt:** _____

Totally Incapacitated/Unable to Work From _____ **To**_____

Diagnosis: _____

Plan of Care/Treatment: _____

Referral/Diagnostics/PT: _____

Released To Work:

☐ **Without Restrictions** **Date:** _____

☐ **With Restrictions** **Date:** _____

Maximum Lift/Push/Pull: _____ pounds

Other: _____

☐ Sling
☐ Crutches
☐ Cast/Brace
☐ No above shoulder work
☐ No squatting/kneeling

Physician's Signature: _____ **Date:**_____

Please return this completed form to Michelle Gallagher RN (I/N Occupational Health Nurse)
Fax # 574-654-1700 Phone # 574-654-1313