EMPLOYEE'S WORK LIMITATION SLIP

☐ **Occupational** ☐ **Non-occupational** Date _____

Employer _____

Employee _____

The above named employee is under treatment in this office.

☐ Employee is able to perform his/her regular work ☐ Yes ☐ No
☐ Full time ☐ Part time
☐ Employee is able to perform light work ☐ Yes ☐ No

We recommend that his/her work be limited as follows:

No excessive or repeated:

☐ Bending ☐ Kneeling ☐ Twisting ☐ Climbing ☐ Squatting
☐ Stooping ☐ Pulling ☐ Pushing ☐ Reaching above shoulder

No prolonged:

☐ Standing ☐ Sitting ☐ Walking (In excess of ____% work shift)

☐ No lifting over 10 lbs. ☐ No lifting over 50 lbs.
☐ No lifting over 20 lbs. ☐ No lifting over 100 lbs.
☐ No hazardous machinery
☐ Avoid dusts and fumes
☐ Avoid contact with harmful agents or skin irritants
☐ Restrict to noise free area
☐ Avoid jobs requiring good depth perception or near point fusion

Other Restrictions:

☐ _____

☐ _____

Limitation will be temporary for _____ days _____ weeks _____ months

Diagnosis: _____

Remarks: _____

_____

☐ Badge change recommended ☐ Badge change not recommended

Provider's Name (typed) _____

Signature _____

#28
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