

I, _____, have received and read the *Requirement for*
(Name – Print)
Medical Evaluation and position description for my patient,

_____.
Patient's Name - Print

Having read this information, and having been given the opportunity to seek additional information concerning the duties of a _____, I am making the
Position Title
following recommendations concerning the work status of my patient:

- For the period beginning _____ through _____, the
Date Date
employee may continue to perform all duties required for the position.

- The employee is able to perform the duties required with the restrictions/accommodations specified herein:

- The employee is unable to work.
- Other:

It is my understanding that my patient's employing agency is relying on my medical determination(s) and recommendation(s) in determining the appropriate work assignments and accommodations for my patient. In this regard, the recommendation(s) noted above is/are my best medical judgement of the physical and/or mental capabilities of my patient to perform the essential duties of his/her position.

Physician's Name:

Physician's Address/Telephone Number:

(Print or Type)

(Signature)

(Date)