Attending Physician's Return to Work Report – Form Instructions

Purpose of the form:
The Attending Physician's Return to Work Report should be completed when an employee is released to return to work from to any of the following:

- Treatment for a significant illness or injury requiring hospitalization or surgical intervention
- Any medical condition that may impact an employee's performance or safety on the job
- Any medical absence of 7 days or more. The information is used to determine Fitness for Duty on returning to work in a safety critical work environment.

Who completes the form:
The **employee completes the top portion of the form in its entirety** to prevent processing delays. The remainder of the form should be completed by each of the employee's treating physicians or other appropriate licensed treating healthcare providers. **The healthcare provider or employee should return the completed form along with any additional treatment information to**:

1. Email: Notifyhealthservices@nscorp.com
2. Fax: 470-463-5081

Contact information:
If you have questions about the Attending Physician's Return to Work Report, you can email Notifyhealthservices@nscorp.com.

Additional Instructions for Certain Diagnoses

If any of the conditions named below apply, please provide the additional information requested along with this report. **Office visit notes are required on each relevant condition, summaries are not sufficient for determination of clearance**. Additional information may be requested after initial review.

SURGICAL PROCEDURE
If employee underwent a surgical procedure: provide operative note and last post-operative note. If physical therapy (PT) was prescribed, submit PT discharge note.

CARDIAC ISSUE
If employee is suffering from heart disease: submit three most recent office visit notes, report indicating most recent ejection fraction (echocardiogram, nuclear study, or catheterization report if applicable), recent Bruce protocol stress test report, Holter monitoring report, or results of any other specialized testing that may have been performed in the course of evaluation and treatment (if not already performed, any tests used to determine fitness for duty will be at the employee's expense).

DIABETES
If employee is suffering from diabetes mellitus: a fasting blood sugar and glycosylated hemoglobin (Hgb A1C) performed within the last thirty (30) days; prescribed diet; frequency, nature and severity of any symptomatic hypoglycemic or hyperglycemic episodes or reactions in the past six months; state of employee's compliance with treatment regimen; frequency of employee's visits to you for monitoring and nature of any employee self-monitoring; nature, severity and extent of any diabetic complications (e.g., retinopathy, neuropathy, etc.); ability of employee to recognize and manage hypoglycemic reactions. Submit most recent office visit note.

NEUROLOGICAL ISSUE
If employee is suffering from seizure disorder, stroke/TIA, TBI or disturbance of consciousness: frequency, nature and severity of any seizures, disturbances of consciousness, syncope, or dizziness:

in past one year; results of recent neurological examination; results of any tests (e.g., EEG, brain scan, blood levels of medications, etc.) that may have been performed; state of employee's compliance with treatment regimen; frequency of employee's visits to you for monitoring. Submit three most recent office visit notes.

SLEEP DISORDER

If employee has been diagnosed with a sleep disorder submit most recent office visit note; copies of applicable test report (sleep study, MSLT, MWT) before and after treatment along with treatment compliance report to verify using device as recommended by treating provider.

ORTHOPEDIC ISSUE

If employee is being treated for an orthopedic condition or injury (conditions related to the neck or back or involving the upper and lower extremities): Submit three most recent office visit notes specifying physical abilities, strength, ROM, or any physical limitations, copy of 3 most recent physical therapy reports including a discharge summary, and imaging studies (MRI, CT, X-ray) if applicable.

SUBSTANCE ABUSE

If employee is suffering from substance abuse: copy of results of any recent alcohol and/or drug testing; details of rehabilitation and recovery plan; nature, extent and severity of any complications of substance abuse. Employee will also be required to contact the NS Employee Assistance Program.

MENTAL HEALTH DISORDER

Three most recent office visit notes. If employee has been hospitalized, submit the discharge summary and three most recent post hospitalization office visit notes.

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Form to be completed and submitted when an employee is released to return to work following treatment for: a significant illness or injury requiring hospitalization or surgical intervention, any medical condition that may impact an employee's performance or safety on the job or following any medical absence of 7 days or more. Failure to attach all applicable documentation requested on page 1 of this form will delay your return to work clearance. Summaries of office visit notes are not accepted. ***Please print clearly. illegible forms will be returned to the employee.***

Employee Name		DOB	Employee Mobile Number
Employee Personal Email			
Address			
Last 4 SSN	I.D. Number	Occupation/Craft	
Supervisor Name		Supervisor Phone Number	
Department		Work Location	

Last Date Worked: _____

Employee Claims On-Duty Injury: ☐ Yes ☐ No. If yes, see page 6.

The above employee has reported that he has been under your professional care. To enable his consideration his return to work, please complete the remaining portion of this report in its entirety. For certain diagnoses or conditions specific additional treatment information may be required. See instructions on page 1. Please contact notifyhealthservices@nscorp.com if any clarification regarding job duties or further discussion is desired.

A copy of recent medical records may be submitted in lieu of completion of this form provided all necessary information identified below is included in the medical records.

Please complete this form in its entirety and return all attachments to health services at the email or fax above.

All information will be treated confidentially. Thank you.

1. Chief Complaint / History: _____

2. Current Vitals: BP_____Ht_____Wt_____If treating Diabetes: HgbA1c_____Fasting BS _____

3. Current Physical Exam Findings: _____

4. Diagnoses with ICD Codes: _____

5. Treatments: (include procedures or surgeries and dates performed)_____

6. Current medications with dosages and frequency: (may attach separate medication list) _____

7. Will any medication employee is taking adversely affect alertness, coordination, judgment, vision, or gait?

   Please check one: ☐ Yes ☐ No

   If yes, please explain: _____

8. Date of Next Visit (if any) : _____

9. For the current episode of care what date range or individual dates was the employee unable to work?

   From_____To_____OR Individual Dates: _____

10. Prognosis: _____

11. The employee is able to perform his/her assignment without posing a direct threat to his/her own safety or the safety of others on (return date should not be more than two weeks in advance of last assessment):

    Return to Work Date:_____ ☐ Without Restrictions

    ☐ With Restrictions

(Whether a person poses a "direct threat" to himself/herself, or others must be based on the most current medical knowledge and/or the best available objective evidence about this individual. There must be a significant risk of substantial harm; the risk may not be speculative or remote. In reaching your conclusion, you should consider the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur and the imminence of the potential harm. If you conclude that this person would pose a "direct threat" please provide us with the basis for your conclusion addressing the issues noted above.)

12. Please specify any recommended activity restrictions, limitations, or accommodations: _____

_____

_____

Restrictions are: ☐ Permanent ☐ Temporary

If temporary, how long will recommended work restrictions be in effect? _____

_____

_____ _____

Signature of Treating Healthcare Provider Date

_____

Print Name

_____

Specialty

_____

Phone & Fax Number

_____

Street Address

_____

City, State, Zip

Information to Submit if Claimed as On-Duty Injury

- If applicable, Emergency room, Urgent Care, or other initial evaluation records
- Initial Office visit notes from all treating health care providers (including any treating specialist) and include most recent one-year OV notes including return to work recommendations.
- If applicable, recommended work restrictions and/or accommodations, and if any, their anticipated duration from any treating health care provider (including any treating orthopedic doctor's)
- Admission note and discharge summary for all hospitalizations
- If applicable, Operative report, if applicable – Either from surgeon's office or hospital where the surgery was performed. It is not necessary to provide all hospital records.
- All diagnostic study reports, such as X-ray, MRI, EMG - please do not send X-ray or MRI films!
- If applicable, Physical therapy initial evaluation and discharge summary along with last three therapy notes, if applicable
- IME, FCE or other similar evaluations, if applicable