

“CONFIDENTIAL”

DOCTOR'S EVALUATION OF INJURY/ILLNESS
To be completed by Physician

Patient Name: _____ **Last 4 Digits SSN:** _____

Injury Date/Time: _____ **Date of Exam:** _____ **Time In:** _____ **Time Out:** _____

Injury Type: Work-Related Not Work-Related

TO ATTENDING PHYSICIAN:

If this is a work-related injury/illness, please treat the above injured/ill worker in accordance with the terms of the Workers' Compensation laws. Subsequent treatment for a work-related injury must be authorized by the State Compensation Insurance Fund (SCIF).

The original Doctor's Evaluation of Injury/Illness should be returned to the injured/ill employee, who will then be responsible for providing it to his/her Supervisor or Center Clerk.

They responsibility of the Physician to send a copy of the "Doctor's Evaluation of Injury/Illness" and a "Doctor's First Report of Occupational Injury or Illness" the California Conservation Corps, Health & Safety Unit at 1719 24th Street; Sacramento CA 95816 AND the SCIF office marked below:

- | | | |
|--|---|---|
| <input type="checkbox"/> P.O. Box 9010932
Commerce, CA 90091-0932 | <input type="checkbox"/> P.O. Box 9230
Oxnard, CA 93031-9045 | <input type="checkbox"/> P.O. Box 1609
Rohnert Park, CA 94927-1609 |
| <input type="checkbox"/> P.O. Box 4973
Eureka, CA 95502-4973 | <input type="checkbox"/> P.O. Box 59901
Riverside, CA 92517-1901 | <input type="checkbox"/> P.O. Box 3171
Sacramento, CA 94585 |

Body Part:

Exam Type: First Aid Only Initial Evaluation/Treatment Follow-up
 Consultation Only Other

Job Description/Job Analysis Reviewed: Yes No

Work Status:

Return to Full Duty with No Restrictions On _____ (Date)

Return to Work with Restrictions (see below) On _____ (Date)

Remain Off Duty until: _____ (Date)

DOCTOR'S EVALUATION OF INJURY/ILLNESS

CCC 272 (Revised 03/09)

Work Restrictions: Patient is restricted from or limited in performing the following functions:

Check activity and enter limitation (e.g., frequency, duration, weight, or other notation)

<input type="checkbox"/> Keyboarding/Typing:
<input type="checkbox"/> Squat/Kneel:
<input type="checkbox"/> Sit:
<input type="checkbox"/> Drive:
<input type="checkbox"/> Stand:
<input type="checkbox"/> Walk:
<input type="checkbox"/> Bend:
<input type="checkbox"/> Stoop:
<input type="checkbox"/> Climb Ladders:
<input type="checkbox"/> Climb Stairs:
<input type="checkbox"/> Push/Pull:
<input type="checkbox"/> Grip/Grasp:
<input type="checkbox"/> Twist:
<input type="checkbox"/> Reach Overhead:
<input type="checkbox"/> Use Machinery:
<input type="checkbox"/> Lift: <input type="checkbox"/> 0-10 lbs <input type="checkbox"/> 11-25 lbs <input type="checkbox"/> 26-40 lbs <input type="checkbox"/> More than 40 lbs
<input type="checkbox"/> Carry: <input type="checkbox"/> 0-10 lbs <input type="checkbox"/> 11-25 lbs <input type="checkbox"/> 26-40 lbs <input type="checkbox"/> More than 40 lbs
<input type="checkbox"/> Work Precautions:
<input type="checkbox"/> Assistive Device(s) Required: Type: _____ Length of Time: _____
<input type="checkbox"/> Environmental (Avoid dust, etc.):
<input type="checkbox"/> Other:

Off Duty Restrictions:

Same as above Additional: _____

Further Treatment Needed: Yes No

Patient is Permanent and Stationary: Yes No

Permanent Disability Expected: Yes No Unknown
(This opinion is not binding as the patient's condition may improve or worsen in the future.)

Treatment: Physical Therapy Hand Therapy Other: _____

Testing: CT Scan MRI EMG X-Ray Other: _____

Testing Date/Time: _____

Referred for Evaluation with: _____ **Clinic:** _____

Comments:

Next Appointment Date/Time: _____ **Clinic:** _____

I, the treating physician, have not violated Labor Code Section 139.3. The contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Print Name: _____ **Signature:** _____

Clinic: _____ **Phone:** _____ **Date:** _____