

MEDICAL AUTHORIZATION / RETURN TO WORK

MEDICAL PROVIDER PLEASE NOTE:

- 1: THIS EMPLOYEE HAS ALLEGED AN OCCUPATIONAL INJURY / ILLNESS. UPON RECEIPT OF THIS FORM, AND WITH OTHER DOCUMENTS, THE NC DOT'S WORKERS COMP UNIT WILL DETERMINE IF LIABILITY WILL BE ACCEPTED.
- 2: IF THE INJURY IS ONE NORMALLY COVERED UNDER THE STATE WORKERS' COMPENSATION ACT, YOU ARE AUTHORIZED TO PROVIDE MEDICAL TREATMENT.
- 3: COMPLETE THE PROVIDERS SECTION, MAKE A COPY FOR YOUR RECORDS AND GIVE THE ORIGINAL TO THE EMPLOYEE.
- 4: SUBMIT ALL MEDICAL REPORTS AND BILLS TO THIS ADDRESS: _

NC Department of Transportation
1594 Mail Service Center
Raleigh NC 27699-1594
Phone 919-250-4200 Fax 919-212-3121

NOTE: NC DEPARTMENT OF TRANSPORTATION ADMITS NO LIABILITY WITH THIS AUTHORIZATION.

Employee: _____ Date of Birth: _____
 Date of Injury: _____ SS #: _____
 Medical Provider: _____
 Address: _____ City/State: _____
 Phone Number: _____ Fax Number: _____

Provider to complete this section forward.

Diagnosis: _____

Treatment : _____

Medications: _____

Remarks / Comments) _____

Restrictions:

- | | |
|---|--|
| _____ Lifting / Carrying limit of _____ lbs. | _____ No crawling |
| _____ No bending, stooping or squatting | _____ No stairs / ladders climbing |
| _____ No pushing or pulling with arms / legs / body. | _____ No extended walking |
| _____ No activities above shoulder level / waist level | _____ No twisting or turning |
| _____ No repetitive motion _____ | _____ One handed work only (R) (L) |
| _____ Limited / light use of _____ extremity | _____ Sitting work only |
| _____ Avoid repetitive bending, stooping, squatting, twisting and turning | _____ OTHER: |
| _____ Avoid prolonged sitting, alternate sitting / standing as needed | _____ No Restrictions |
| _____ No sitting without breaks every _____ minutes / hours | _____ Regular Duty |
| _____ No standing without breaks every _____ minutes / hours | _____ Released from Doctors Care: |

Is employee able to work eight hours a day ? **YES NO** Return to work: Date: _____
 Has employee reached MAXIMUM MEDICAL IMPROVEMENT: Yes Date: _____ No Date: _____

PHYSICAL / OCCUPATIONAL THERAPY: _____
 NEXT PHYSICIAN APPOINTMENT: _____
 MRI: _____ Nerve Conduction: _____

Attending Physician Signature: _____ **Name (print)** _____ **Date:** _____

QUESTIONS ABOUT EMPLOYEE'S JOB DUTIES, CONTACT LOCAL DOT OFFICE

DOT OFFICE: _____
 ADDRESS: _____
 CITY : _____
 PHONE: _____

Supervisor/Risk Manager: