



City of Memphis Injury On Duty (IOD) Attending Physician Form & Physical Therapy Note

Medical Facility: _____ Front Desk Initials: _____ Date: ___/___/___ Time In: _____ Time Out: _____

(To be completed by Employee)
EMPLOYEE NAME: _____ HOME #: _____ WORK #: _____

DATE OF BIRTH: _____ SSN: _____ DIVISION: _____ DEPT: _____

DATE OF INJURY: ___/___/___ TIME OF INJURY: _____ SUPERVISOR NAME: _____

(To be completed by Treating Physician)
INJURY: _____

ASSESSMENT/DIAGNOSIS: _____

Is condition work related? [] Yes [] No Any known pre-existing or other conditions contributing? [] Yes [] No; if so explain _____

Treatment Rendered: _____

MEDICATIONS Prescribed: [] Narcotic Medication: _____ [] Other Medication: _____ Frequency: _____

[] Do not take while working [] Do not take while driving

WORK STATUS - SELECT ONE ONLY

[] NO RESTRICTIONS/ RETURN TO REGULAR DUTY
(CHECK ALL THAT APPLY)

DISCHARGE FROM CARE DISCHARGE DATE: ___/___/___
MMI MMI DATE: ___/___/___

[] RESTRICTIONS/ RETURN TO LIMITED DUTY START DATE: ___/___/___ END DATE: ___/___/___
(CHECK ALL THAT APPLY)

Limited/Transitional
Permanent Restrictions

UPPER EXTREMITY

- No use of injured hand/arm
No repetitive overhead work
No lift/push/pull over ___ lbs.
No repetitive/heavy gripping
No use of vibrating tools
No repetitive/outstretched arm use

BACK

- Sitting job only
Alternate sit/stand
May stand/walk up to ___ hrs. /day
No repetitive stoop/bend/twist
May stoop/bend/twist ___ times/hour
Weight limit ___ lbs.

Other _____

LOWER EXTREMITY

- Sitting job with foot/leg elevated
Alternate sit/stand, may walk
Short distances
No squatting or kneeling

OTHER

- Keep dressing clean/dry
Injury prohibits driving while at work
No use of hazardous machinery
Medications may cause drowsiness

Other _____

[] UNABLE TO WORK START DATE: ___/___/___ END DATE: ___/___/___

FOLLOW UP APPT. REQUIRED? [] YES [] NO [] AS NEEDED DATE: ___/___/___ TIME: _____ Pre Authorization Required? [] YES [] NO

REFERRAL To: Specialty: _____ Therapy: _____ Diagnostic Testing: _____ (TPA to make referral)

Comments: _____

Physician Name _____ Physician Signature: _____ Date: ___/___/___
(Print Name)

PHYSICAL THERAPY NOTE: Therapist Name: _____ Therapist Signature: _____

Date: ___/___/___ Start Time: _____ End Time: _____ Did Employee Attend: Y/N _____

No. of sessions approved: _____ No. of Sessions Remaining: _____ Next Therapy appointment: _____ Time: _____

FORM TO BE COMPLETED AND SIGNED BY TREATING PHYSICIAN/THERAPIST OR HIS/HER DESIGNEE.
FAX COMPLETED COPY TO SEDGWICK AT (901)566-3415 and Division OSHA Coordinator at _____. PLEASE GIVE EMPLOYEE
COPY OF THIS FORM TO RETURN TO SUPERVISOR. **UPON DISCHARGE FROM MEDICAL FACILITY and IF SPECIALTY CARE IS NEEDED,
EMPLOYEE MUST MAKE IMMEDIATE CONTACT WITH SUPERVISOR/OSHA REP FOR RETURN TO WORK INSTRUCTIONS AND SEDGWICK FOR
FOLLOW-UP CARE INSTRUCTIONS ** Form Revised as of 10/2012**

