ASU Treatment and Return to Work Authorization

Employee Must Return A Copy of This Form to the Supervisor Immediately After Visit

Please render necessary treatment to care for the injury sustained by:

________________________________ ______/______/______ ☐ **Initial Evaluation**
Name of Injured Employee **Date Of Birth** ☐ **Follow Up Visit**

ASU Banner Employee ID Number: ____

Type of Injury: **Cause of Injury:**

Appalachian State University liability for subsequent treatment is governed solely by the provisions of the N. C. Workers' Compensation Act

Supervisor's Name: ____________________**Signature:**______________ **Ext:**______ **Date:**___/____/___

Disposition App. State University has a transitional work program for employees who have been injured at work.

Accommodations will be made in accordance with physician's instructions.

INITIAL TREATING PHYSICIAN STATEMENT

☐ May return to work on ______________________ without restrictions or limitations.
(Date)

☐ May return to work on ______________________ with the following restrictions or limitations:
(Date)

☐ No lifting over ____ pounds ☐ No/Limited stooping, squatting, bending, crouching, or climbing (circle)

☐ No prolonged standing/walking ☐ Other ____

These restrictions or limitations should be in effect until: _________________________________

☐ Should not return to work until evaluated by a consulting physician

Referred to:____Appointment: _____/____/____ (Date) _______ (Time)

Diagnosis/HX:____

Physician's Name _____________________________ Signature: ___________________ Date:_________

Referral/Consulting Physician's Statement

☐ May return to work on ______________________ without restrictions or limitations.
(Date)

☐ May return to work on ______________________ with the following restrictions or limitations:
(Date)

☐ No lifting over ____ pounds ☐ No/Limited stooping, squatting, bending, crouching, or climbing (circle)

☐ No prolonged standing/walking ☐ Other ____

These restrictions or limitations should be in effect until: _________________________________

☐ Should not return to work until _______________ Return Appointment _______________________

Diagnosis/Comments: ____

Physician's Name: __________________________ Signature: ___________________ Date:_________

Release of Information: I hereby authorize the Consulting Physician's Office to release information regarding this referral to:

Appalachian State University, PO Box 32112, Boone, NC 28608 ____

Revised 4/2008 Signature of Patient Date