

CC-FORM-5

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

Created 2-1-14

THIS SPACE FOR COMMISSION USE ONLY

SEND COPIES TO:
1 - Employee/Claimant
1 - All Other Parties of Record

PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS

In re claim of:

Full Name of Employee (Claimant)
Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

COMMISSION FILE NO.	
Date of Injury	Diagnosis
Part of Body	Date of Exam

I. RELEASED FOR WORK?	<input type="checkbox"/> YES, released to: <input type="checkbox"/> Regular Work (date): <input type="checkbox"/> Modified Work (date): Give Restrictions (complete Section II)
	<input type="checkbox"/> NO, claimant remains temporarily totally disabled.

II. RESTRICTIONS (check all that apply and describe fully under number 8 below)

No Restrictions Permanent Restrictions Temporary Restrictions

- Restricted lifting (maximum weight in pounds) 10__ 25__ 50__ Other__ Frequency _____
- Restricted pushing/pulling of _____ lbs.
- Restricted reaching: above chest overhead away from body
- Restricted to one-handed duty. No use of: Right hand Left hand
- Restricted walking standing sitting (describe fully) partial weight bearing (describe fully) bending twisting
- Wear splint at: All Times Work Night (describe fully)
- DO NOT: Operate Machinery Crawl Kneel Squat Drive any Vehicle Climb Bend
 Stoop Twist
- FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:

III. MEDICAL & REHABILITATION

- Is continuing medical maintenance needed? NO YES If YES, describe fully, including date of next appointment. Supplement with extra pages if needed.
- Is vocational rehabilitation indicated? (i.e. As a result of the injury, is the employee unable to perform work for which the person has previous training or experience?) NO YES

I declare under PENALTY OF PERJURY that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Employee/Counsel
Address (Number & Street)
City State Zip Code

Employer/Counsel
Address (Number & Street)
City State Zip Code

Signed this _____ day of _____, _____.

Signature of Physician
Address (Number & Street)
City State Zip Code
Telephone Number of Physician
Print or type name of Physician