Please check your group from the list below.

- ☐ Massachusetts Retail Merchants Workers' Compensation Group, Inc.
- ☐ Massachusetts Care Self-Insurance Group, Inc. (nursing homes)
- ☐ Massachusetts Healthcare Self-Insurance Group, Inc. (hospitals)
- ☐ Massachusetts Manufacturing Self-Insurance Group, Inc.
- ☐ Massachusetts Trade Self-Insurance Group, Inc.

PO Box 859222-9222, Braintree MA 02185
(781) 843-0005 • (800) 790-8877 • Fax (800) 382-8891

DOCTOR'S REPORT OF TREATMENT

I. THIS PORTION TO BE COMPLETED BY EMPLOYER

Employee Name: _____ Date: _____

Initial Date of Injury/Illness: _____ Contact Person: _____

Employer Name: _____ Telephone: _____

II. THIS PORTION TO BE COMPLETED BY MEDICAL PROVIDER AND RETURNED TO EMPLOYER

Medical Provider Name: _____ Telephone: _____

Address: _____ City/State/Zip: _____

Date of Service: _____

Diagnosis: _____

X-Ray: _____ P.T. _____ Medication: _____

Other: _____

EMPLOYEE WORK STATUS: **ATTENTION MODIFIED DUTY IS AVAILABLE**

Employee can return to duty on: _____ (date)

Employee can return to work on: _____ (date) **with restrictions noted below for** _____ (duration)

Employee cannot return to work at this time. (Projected date for return to work: _____**)**

Please check off applicable boxes:

Lifting Limited to:	Carrying Limited to:	Push/Pull Limited to:	Position Limitation:
1-5 lbs. ☐	1-5 lbs. ☐	1-5 lbs. ☐	No Exposure to Vibrating Tools ☐
6-10 lbs. ☐	6-10 lbs. ☐	6-10 lbs. ☐	No Repetitive Finger Motion ☐
11-25 lbs. ☐	11-25 lbs. ☐	11-25 lbs. ☐	No Repetitive Wrist Motion ☐
26-40 lbs. ☐	26-40 lbs. ☐	26-40 lbs. ☐	No Reaching Above Shoulders ☐
41-75 lbs. ☐	41-75 lbs. ☐	41-75 lbs. ☐	No Reaching below waist ☐
			Avoid Extremes of Neck ☐
			No Driving ☐

Physician's Signature: _____

Next Appointment at Occupational Health Services:

Day: _____ Date: _____ Time: _____

Physician: _____ Date: _____

I hereby authorize _____ to perform medical services and disclose to my employer any information concerning my condition.

Employee Signature: _____ Date: _____

Print Form