

**ATTENDING PHYSICIAN'S STATEMENT**

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Employee: \_\_\_\_\_

Smith ID Number: \_\_\_\_\_

Current Position: \_\_\_\_\_

Department: \_\_\_\_\_

The employee listed above has identified a medical condition which affects his/her employment. Please provide the following information to assist us with an evaluation of this employee's work capabilities. If you have any questions, you may contact the Office of Human Resources at (413) 585-2275, fax (413) 585-2284. **Please return this completed form to Human Resources, 30 Belmont Avenue, Northampton, MA 01063.**

**MEDICAL INFORMATION****1. Diagnosis of Medical Condition:** \_\_\_\_\_  
\_\_\_\_\_

NOTE: For pregnancies, please identify expected date of delivery and any medical reason at this time which would prevent this employee from working up to her expected date of delivery.

**2. Date employee became unable to work due to medical condition:** \_\_\_\_\_**TREATMENT****3. Brief description of treatment plan (include frequency of treatments):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**RESTRICTIONS****Please Check Any Appropriate Box:**

- |  |  |                                      |                                      |                                      |  |
|--|--|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Work Restrictions:            | <input type="checkbox"/> 2 hours/day                       | <input type="checkbox"/> 4 hours/day | <input type="checkbox"/> 6 hours/day | <input type="checkbox"/> 8 hours/day | <input type="checkbox"/> > 8 hours/day |
| <input type="checkbox"/> Sitting Only                  | <input type="checkbox"/> No Lifting                        | <input type="checkbox"/> No Kneeling |                                      |                                      |  |
| <input type="checkbox"/> No exp. To dust/fumes, etc.   | <input type="checkbox"/> Sit/stand as needed               | <input type="checkbox"/> No Reaching |                                      |                                      |  |
| <input type="checkbox"/> Dry work only                 | <input type="checkbox"/> Available for Overtime            | <input type="checkbox"/> No Bending  |                                      |                                      |  |
| <input type="checkbox"/> Use of dominant hand/arm only | <input type="checkbox"/> Use of non dominant hand/arm only | <input type="checkbox"/> No Work     |                                      |                                      |  |
| <input type="checkbox"/> No Driving                    |  |                                      |                                      |                                      |  |
| <input type="checkbox"/> Lifting up to:                | <input type="checkbox"/> 10 lbs                            | <input type="checkbox"/> 11-15 lbs   | <input type="checkbox"/> 16-25 lbs   | <input type="checkbox"/> 26-40 lbs   | <input type="checkbox"/> >45 lbs       |

Above restrictions are in place for \_\_\_\_\_  Days  Weeks  Months**PHYSICIAN'S NAME** (please print): \_\_\_\_\_**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_

Date: \_\_\_\_\_