

New York State Unified Court System

Health Care Provider Certification for Employee's Return to Work

SECTION I: To be completed by the COURT/AGENCY

Court / Agency:	Contact:		
Name:			
First	Middle	Last	
Job Title:	Regular Work Sch	edule:	<u> </u>
Essential Job Functions:			
,			
-			
approval is granted, we must ascertain that the following questions based on your medical know Provider's name	ledge, experience, and examin	ation of the patient. ope of practice / specialty	e answer the
			<u></u>
Street Address	City	State	Zip
() () Telephone	Fax .	E-mail	
PART A: Medical Facts			
Approximate date condition commenced:	Probable du	ıration:	
Date(s) you treated the patient for condition:			
Was medication, other than over-the-counter	medication, prescribed?		_NoYes
are one make the control of the cont	للعالة والمرافقة فالمادة والمرافقة فللمادة والمرافقة وال	ig the property of the speciments of the specime	

If so, what is the effective date?	If so, what is the effective date? 3. Is the employee unable to perform any of his/her job functions due to the condition? Check if Title Standard was provided: If so, identify the job functions the employee is unable to perform: Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced scheme.	If so, what is the effective date?	Is the employee cleared to return to work?	No _	_Ye
3. Is the employee unable to perform any of his/her job functions due to the condition?NoYet Check if Title Standard was provided: If so, identify the job functions the employee is unable to perform: 4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?NoYe If so, are the treatments or the reduced number of hours of work medically necessary?NoYe	3. Is the employee unable to perform any of his/her job functions due to the condition? Check if Title Standard was provided: If so, identify the job functions the employee is unable to perform: 4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced scheme.	3. Is the employee unable to perform any of his/her job functions due to the condition?NoNoNo			
If so, identify the job functions the employee is unable to perform: 4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? NoYe If so, are the treatments or the reduced number of hours of work medically necessary? NoYe	If so, identify the job functions the employee is unable to perform: 4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced scheme.	4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? If so, are the treatments or the reduced number of hours of work medically necessary? Estimate the part-time or reduced work schedule the employee needs, if any: hour(s) per day; days per week from through	Is the employee unable to perform any of his/her job functions due to the condition?	No	Ye:
because of the employee's medical condition? If so, are the treatments or the reduced number of hours of work medically necessary? NoYe	4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced scheme of the application and the application of the application and the applicati	because of the employee's medical condition?NoNoNoNoNoNoNoNoNoNoNoNoNoNoNoNo			
······································	If so, are the treatments or the reduced number of hours of work medically necessary? Estimate the part-time or reduced work schedule the employee needs, if any:		because of the employee's medical condition? If so, are the treatments or the reduced number of hours of work medically necessary? Estimate the part-time or reduced work schedule the employee needs, if any:	NO _	1 C
Attach additional information if necessary					
•				Is the employee unable to perform any of his/her job functions due to the condition? Check if Title Standard was provided: If so, identify the job functions the employee is unable to perform: Will the employee need to attend follow-up treatment appointments or work part-time or on a received seed to a steel condition? If so, are the treatments or the reduced number of hours of work medically necessary? Estimate the part-time or reduced work schedule the employee needs, if any: hour(s) per day; days per week from through	Is the employee unable to perform any of his/her job functions due to the condition? Check if Title Standard was provided: If so, identify the job functions the employee is unable to perform: Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced sche because of the employee's medical condition? If so, are the treatments or the reduced number of hours of work medically necessary? — No Estimate the part-time or reduced work schedule the employee needs, if any:

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ESTIMATED PHYSICAL CAPABILITIES FORM FOR MYS COURT EMPLOYEES

PLOYEE NAME:		TITLE:		WORK LO	CATION:	
S FORM MUST BE CO	MPLETED BY HEA	LTH CARE PROVIDER:				
TRUCTIONS: Provi	de medical diagn	osis including a detailed o	description	of the above-na	med individual's	injury or illnes
prognosis for reco						
			<u></u>	<u>, , , , , , , , , , , , , , , , , , , </u>	<u> </u>	
	<u></u>				······································	
lease check appropria	ato haves for all au-	estions below.		. , , , , , , , , , , , , , , , , , , ,		<u>, , , , , , , , , , , , , , , , , , , </u>
. In an eight-hour work			N	- Mith Casts		
Sit □ 1 Stand - □ 1	□2 □3 □4	□5 □6 □7 □8 □C	Continuously Continuously	□ With Rests □ With Rests		
r i carri			Continuously	□ With Rests		
In a given day, for ho	w many total hours o	an this employee sit, stand, and	d/or walk in co	mbination?		
□4 □6	□ 8	□ 10 □ 12 □ 1	4 🗆 1	6		
Other capabilities:						
Ne	ver Occasionally	Frequently Continuously	Upper Ext	remities:		
LIFT			Which han	d is dominant?	□ Right	□ Left
00-10 lbs.			Can this er	nployee perform re	petitive actions such	i as:
11-20 lbs.			Landsha Phan Pina Barra Santa Sa	Simple Grasping	Pushing & Pulling	Fine Manipulation
21-50 lbs.			RIGHT			DY DN
51-100 lbs.			LEFT			
CARRY			Lower Ext	remities:		<u></u>
00-10 lbs.			erzet (g. 1808-1991 (g. 1873), g. 1873 (g. 1874) (g. 1874) (g. 1874)	t/legs for repetitive	movement, as in	and the control of control of the co
			operation	of foot controls or r	notor vehicles.	
11-20 lbs.				RIGHT	LEFT	SIMULTANEOUS
21-50 lbs.						
51-100 lbs.						
BEND					DY DN	
SQUAT			Does this employee have any visual or hearing			
			explain.	C. C	• • · · · · · · · · · · · · · · · · · ·	
CLIMB				your examination(s		
			nature, inc	- -	tions prescribed for	
RUN			n —	sis listed, that wou returning to work?		
Reach above			explain.	~		
shoulder level	with the latest the second to			Va p = p = p = - 441 - 441 - 4 11 - 4 11 12 12 12 14 14 14 14 14 14 14 14 14 14 14 14 14		·· :
Operate a motor vechicle			Can this e	mployee operate m	noving machinery?	DY DN
	<u></u>		<u></u>			:
When, in your esti	mation, will this e	employee be ready to retur	n to work?	Date:		
		<u></u>				<u></u>
	, , , , , , , , , , , , , , , , , , ,				TELEPHONE:	
		<u>, , , , , , , , , , , , , , , , , , , </u>		· · · · · · · · · · · · · · · · · · ·	1 Brestander 2 Nach 1 Nach 2 Nach	<u></u>
PE OF PRACTICE/ME	DICAL SPECIALTY	• •		······································		
ALTH CARE PROVIDI	ER'S SIGNATURE:				DATE:	//