BAPTIST HEALTH®

Employee Post- Incident Care Work Note

Employee Last / First Name: _____ **Date of Injury:** ____ / ____ / _____

Date of Birth: ____ / ____ / _____

Treating practitioner: Please provide the following information and fax to 859-639-1971 or forward to BHSWorkCompTeam@BHSI.com.

Diagnosis:

_____

Restrictions:

In accordance with this patient's physical capability, check all that apply. For OSHA reporting purposes, list the date the employee is able to return, regardless of their work schedule.

- ☐ May resume/return to work with no restrictions on ____ / ____ / _____.
- ☐ May resume work on ____ / ____ / _____, with the following restrictions until ____ / ____ / _____:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - ☐ Light work (lifting less than 20 pounds)
  - ☐ Medium work (lifting less than 50 pounds)
  - ☐ Limited hours: _____ hours per day
  - ☐ Limited days: _____ days per week
- ☐ Other: _____
- ☐ Repetitive motion restrictions (specific to hand/arm injuries):

Frequency:	No Use	Occasionally	Frequent	Constant
LEFT	☐	☐	☐	☐
RIGHT	☐	☐	☐	☐

- ☐ Patient is unable to return to work in any capacity.

Return to Work / MMI / Next Appointment:

Date employee may return to work at full duty: ____ / ____ / _____

Projected date of attainment of Maximum Medical Improvement: ____ / ____ / _____

Employee has a return appointment on (date): ____ / ____ / _____ at (time): _____ AM / PM

Ancillary Services:

Please call (866) 866 -1101 if patient requires Physical Therapy, Imaging, DME, Transportation, or Translation Services.

Practitioner Last / First Name: _____ Date: _____

Practitioner Signature: _____

Rev. 9-6-2023