

TRIBAL FIRST

INSURING NATIVE AMERICA

Date: _____

Injured Worker Name: _____

Claim Number: _____

RETURN TO WORK AUTHORIZATION DISABILITY CERTIFICATE

_____ The injured worker is medically and physically able to perform work without restrictions effective: _____.

_____ The injured worker is release for light duty/modified work with the following restrictions:

Anticipated duration of disability is: _____
Please provide the objective medical findings to support disability. ***This is required:***

_____ The injured worker is not released to any type of work based on the following. Please provide the objective medical findings to support disability. ***This is required:*** _____

Anticipated duration of disability is: _____

_____ The injured worker required further treatment _____ YES _____ NO
Diagnosis of all work related conditions are: _____

Next appointment date: _____

Comments: _____

Physician Signature: _____ Date: _____

Print Name: _____ Phone Number: _____