NORTHEASTERN STATE UNIVERSITY
MEDICAL PROVIDER EVALUATION FORM

EMPLOYEE INFORMATION

Employee Name_____ Date _____

Department _____ Supervisor _____

MEDICAL PROVIDER EVALUATION
I have rated the following activities according to my examination of this employee:

ACTIVITY	NOT AT ALL	OCCASIONAL	FREQUENT
Twist	[ ]	[ ]	[ ]
Squat	[ ]	[ ]	[ ]
Climb	[ ]	[ ]	[ ]
Reach	[ ]	[ ]	[ ]
Stand	[ ]	[ ]	[ ]
Sit	[ ]	[ ]	[ ]
Walk	[ ]	[ ]	[ ]
Drive	[ ]	[ ]	[ ]
Lift Over ____ lbs.	[ ]	[ ]	[ ]
Carry Over ____ lbs.	[ ]	[ ]	[ ]
Grasping with Hands	[ ]	[ ]	[ ]
Fine Manipulation with Hands	[ ]	[ ]	[ ]
Pushing/Pulling with Hands	[ ]	[ ]	[ ]
Repetitive Foot Movement	[ ]	[ ]	[ ]
Environmental Exposure (i.e. sun)	[ ]	[ ]	[ ]
Other: _____	[ ]	[ ]	[ ]

Check all that apply:

[ ] Based on my examination of this employee, I recommend that he/she return to work with no restrictions on _____ (DATE).

[ ] Based on my examination of this employee, I recommend that he/she return to work on _____ (DATE).

Type of restriction(s) required: _____

Length of restriction: _____ to _____

MEDICAL PROVIDER'S SIGNATURE: _____

Print Provider's Name: _____ Phone: _____

Provider's Address: _____