Report of Work Ability

Print in ink or type Enter dates in MM/DD/YYYY format

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER

WID numb	er or SSN	Date of in	jury	Date of b	irth			
Employee			•	1				
Employer				e,	1			
Insurer/Sel	If-insurer-TPA					·		
Insurer claim number								
Date of m	ost recent examination by this of	fice						
Select the appropriate option(s) below and fill in the applicable dates.								
	Employee is able to work without			*		_ (date)		
2. E	Employee is able to work with res	strictions,	from	ALINA ENDA ALINA	(date)	to	(date)	
1	The restrictions are:				***************************************			
3. E	Employee is unable to work from	*NEW TOTAL	- Warner -		(date) to _		(date)	
The next scheduled visit is: as needed OR								
Name (Type or Print)				Signature Degree			Degree	
Address				State	License #/Registra	egistration #		
City	V-976-NA-NA-NA	State	ZIP code	Phone #	(include area code)	Date signe	d	