FORM 5

SEND COPIES TO:
1- Employee/Claimant
1 - All Other Parties of Record

COURT OF EXISTING CLAIMS
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

C. 11/02/2015

THIS SPACE FOR COURT USE ONLY

PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS

In re claim of:

Full Name of Employee (Claimant)
Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-______________________
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

WCC FILE NO.	
Date of Injury	Diagnosis
Part of Body	Date of Exam

I. RELEASED FOR WORK?	☐ YES, released to: ☐ Regular Work (date): ☐ Modified Work (date): Give Restrictions (complete Section II)
	☐ NO, claimant remains temporarily totally disabled.

II. RESTRICTIONS (check all that apply and describe fully under number 8 below)

☐ **No Restrictions** ☐ **Permanent Restrictions** ☐ **Temporary Restrictions**

1.___Restricted lifting (maximum weight in pounds) 10___ 25___ 50___ Other____ Frequency ___________
2.___Restricted pushing/pulling of _________ lbs.
3.___Restricted reaching: ☐ above chest ☐ overhead ☐ away from body
4.___Restricted to one-handed duty. No use of: ☐ Right hand ☐ Left hand
5.___Restricted ☐ walking ☐ standing ☐ sitting (describe fully) ☐ partial weight bearing (describe fully) ☐ bending ☐ twisting
6.___Wear splint at: ☐ All Times ☐ Work ☐ Night (describe fully)
7.___DO NOT: ☐ Operate Machinery ☐ Crawl ☐ Kneel ☐ Squat ☐ Drive any Vehicle ☐ Climb ☐ Bend ☐ Stoop ☐ Twist
8. FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:
____

III. MEDICAL & REHABILITATION

A. 1. Is Additional active medical treatment recommended? NO☐ YES☐ If YES, describe fully, including date of next appointment. Supplement with extra pages if needed. ____

2. Is continuing medical maintenance recommended? NO☐ YES☐ If YES, describe fully, including recommended medications, supportive devices, etc. Supplement with extra pages if needed. ______________________________________

B. Is Vocational rehabilitation indicated? (i.e. As a result of the injury, is the employee unable to perform the same occupational duties the employee __ was performing before the injury?) NO☐ YES☐

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Employee/Counsel		
Address (Number & Street)		
City	State	Zip Code

Employer/Counsel		
Address (Number & Street)		
City	State	Zip Code

Signed this________________day of________________, ______.

Signature of Physician		
Address (Number & Street)		
City	State	Zip Code
Telephone Number of Physician		
Print or type name of Physician		