

# PHYSICIAN'S REVIEW OF TRANSITIONAL DUTY

RE: Claimant: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

I have reviewed the description of the alternate duty position for \_\_\_\_\_,  
(claimant's name)

dated \_\_\_\_\_. My recommendation on \_\_\_\_\_'s ability to return  
(date) (claimant's name)

to work in this duty position is:

Worker is able to perform the alternate duty as described.

Worker is able to perform the alternate duty with the following changes:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Worker is unable to perform the alternate duty at this time. Estimated time for  
release to this duty is \_\_\_\_\_.  
(Date)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physicians Name

\_\_\_\_\_  
Phone Number

