

EMPLOYER REQUEST FOR MEDICAL REPORT

This form is an optional tool employers can use to share relevant job information with physicians or other qualified health care professionals when requesting their assessment of an employee's work capacity. Providing this information assists them in providing a report to support safe and appropriate work planning. It should be completed and provided to the physician or health care professional before or at the beginning of the employee's assessment.

Employee First Name: _____

Employee Last Name: _____

Department/Position: _____

Date of Injury/Illness: DD / MM / YYYY

Is this a work-related injury/illness? Yes

No

Job Overview

Summarize the key duties of this role with a focus on any physical demands, cognitive or decision-making requirements and workplace conditions (e.g., shifts, public interaction, weather) that could affect safe or modified work. Clear, specific job information helps the health care professional understand the job context, allowing them to offer information that is relevant and supports safe work planning.

Example: Police Constable (Patrol)

Patrols by vehicle and on foot; frequent public interaction and conflict deescalation. Wears 10 lb duty belt. Typical shift 12 hrs including night duty; requires high alertness/decision-making under time pressure. Long periods of sitting, standing, walking. Periodic running, stair climbing, and physical restraint; variable weather exposure.

Supervisor Signature: _____

Date: DD / MM / YYYY