WORK DISABILITY CERTIFICATE

I, _____, have examined and/or treated
(Name of Doctor)

_____ for injuries sustained in a motor vehicle
(Name of Patient)

accident that occurred on _____.
(Date of Accident)

It is my opinion that, as a result of the injuries received in the motor vehicle accident, the aforementioned patient is:

____ Totally disabled from returning to work from _____ to _____.

____ Partially disabled but may return to work only under the following work restrictions from _____ to _____:

____ Sit-down job duties only.
____ Right hand/arm job duties only.
____ Left hand/arm job duties only.
____ No prolonged sitting.
____ Limited walking.
____ No overhead reaching.
____ No pushing, pulling, stooping or bending.
____ No lifting.
____ No lifting over _____ lbs.
____ Other restrictions: _____

____ Able to return to work without restrictions on _____.

It is my opinion that the aforementioned patient is disabled from working due to the following accident-related injuries/diagnoses: _____

_____

_____

_____

_____
Doctor's Signature

Dated: _____

_____
Doctor's Address