MARSHALL COUNTY SCHOOLS

214 Middle Grave Creek Road
Moundsville, WV 26041

Dear Treating Physician:

The injured worker is employed by Marshall County Schools.

Marshall County Schools has implemented a return to work program. This program is designed to return an injured employee to the workplace as soon as medically feasible. If our injured employee is unable to return to his/her original job, we will make every attempt to return this employee to modified duty or an alternative duty position. We will also ensure that this position meets all medical restrictions that you provide. Our employee is aware of Marshall County School's desire to return him/her to the workplace. If necessary, we are willing to arrange work schedules around diagnostic or treatment appointments.

Enclosed is a Physician Report for you to list restrictions and durations so if possible our employee may be placed in a temporary work assignment performing duties compatible with your restrictions.

Please call me at 304-843-4408 if you have any questions about our return to work program. Thank you in advance for your participation in our efforts to return our injured employee to a safe and productive workplace.

Sincerely,

Corey Murphy
Assistant Superintendent
Marshall County Schools

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PHYSICIAN STATEMENT

Please answer the following questions.

Patient's Name:
Claim #

1. Is your patient capable of returning to work now? ___Yes ___No

2. The employer has a transitional work program. Can the employee return to work with restrictions? ___Yes ___No

3. Released with restrictions on _____(date).

Please provide restrictions and durations, if any. (Please indicate if any of the restrictions are for conditions other than the presenting condition).
Your patient will be placed in a temporary modified/alternative work assignment performing duties compatible with your restrictions.
Occasional lifting up to _____ pounds

Frequent lifting up to _____ pounds

Sitting _____

Standing _____

Climbing _____

Walking _____

Push/Pull _____

Bend/Stoop _____

- Please indicate if restrictions are continuous or in an eight hour period of time.

4. Expected duration of these restrictions: _____

Physician's Signature _____ Date _____