Doctor Notification Letter 8/19/16

# Dear Doctor:

You are treating a valuable employee of our company. We have developed an Early Return-to-Work Program to help in the recovery and rehabilitation of this individual and to assist your patient in the transition to a return to full duty employment.

We would like to work with you and your patient to find a transitional position that will assure your patient’s safe return to work. You have our assurance that we will fully respect the limitations you set forth for this patient. **You are invited to visit our company to actively participate in the approval of suitable transitional work for this employee, if you so desire.** In many instances, employees want to go back to work as soon as medically appropriate to aid in the recovery process.

We ask that you complete the bottom of this form plus the attached **Physical Capabilities Worksheet** to assist us in fully understanding your patient’s limitations and restrictions. Enclosed you also will find a **Job Demands Analysis** of the employee’s duties prior to injury.

This information is required for our workers’ compensation carrier, New York State Insurance Fund. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules allow disclosure of a patient’s protected health information to workers’ compensation insurers, without patient authorization, in compliance with NYS Workers’ Compensation Law.

**ERTW Physician’s Response**

**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NYSIF** **Claim No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Injury Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Exam** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based upon my examination (history, physical evaluation and tests, if any), it is the opinion of this physician that the patient:

 [ ] May resume full duty immediately. [ ] Can return to full duty on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] May resume work immediately [ ] Should return for treatment on: \_\_\_\_\_\_\_\_\_\_

 with the following limitations:

**Comments**

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## Signature of examining physician Date

**cc:** New York State Insurance Fund