ATLANTIC CHARTER
INSURANCE COMPANY

25 New Chardon St • Boston, MA 02114-4721 • Phone: (617) 488-6500 • Fax: (617) 488-6502

DOCTOR'S REPORT OF TREATMENT

I. THIS PORTION TO BE COMPLETED BY EMPLOYER:

Employee Name:_____ Date: _____

Initial Date of Injury/Illness:_____ Contact Person:_____

Employer Name:_____ Telephone #: _____

II. THIS PORTION TO BE COMPLETED BY MEDICAL PROVIDER AND RETURNED TO EMPLOYER.

Medical Provider Name:_____ Telephone #: _____

Address:_____ City/State/Zip:_____

Date of Service:_____

Diagnosis:_____

_____

X-ray:_____ P.T. :_____ Medication: _____

Other: _____

_____

EMPLOYEE WORK STATUS: ** ATTENTION MODIFIED DUTY IS AVAILABLE **

Employee can return to regular duty on: (Date)_____

Employee can return to work on: (Date)_____ with restrictions until: (Date)_____

Employee cannot return to work at this time. Projected date for return to work:_____

Other:_____

Please check off applicable boxes

Lifting Limited to:		Carrying Limited to:		Push/Pull Limited to:		Position Limitation:	
1-5 lbs.		1-5 lbs.		1-5 lbs.		No Exposure to Vibrating Tools	
6-10 lbs.		6-10 lbs.		6-10 lbs.		No Repetitive Finger Motion	
11-25 lbs.		11-25 lbs.		11-25 lbs.		No Repetitive Wrist Motion	
26-40 lbs.		26-40 lbs.		26-40 lbs.		No Reaching Above Shoulders	
41-75 lbs.		41-75 lbs.		41-75 lbs.		No Reaching Below Waist	
						Avoid Extremes of Neck	
						No Driving	

Next medical appointment:

Physician/Location:_____ Date:_____ Time:_____

Physician Signature:_____ Date:_____