

# FORM 5

## SEND COPIES TO:

- 1 - Employee/Claimant
- 1 - All Other Parties of Record

WORKERS' COMPENSATION COURT  
 1915 NORTH STILES  
 OKLAHOMA CITY, OK 73105-4918

Revised 4/06

THIS SPACE FOR COURT USE ONLY

### PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS

In re claim of:

Full Name of Employee (Claimant)
Employee's Social Security Number
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

FILE NO.	
Date of Injury	Diagnosis
Part of Body	Date of Exam

<b>I. RELEASED FOR WORK?</b>	<input type="checkbox"/> YES, released to: <input type="checkbox"/> Regular Work (date): <input type="checkbox"/> Modified Work (date): Give Restrictions (complete Section II)
	<input type="checkbox"/> NO, claimant remains temporarily totally disabled.

**II. RESTRICTIONS (check all that apply and describe fully under number 8 below)**

No Restrictions       Permanent Restrictions       Temporary Restrictions

1. Restricted lifting (maximum weight in pounds) 10\_\_\_ 25\_\_\_ 50\_\_\_ Other\_\_\_ Frequency \_\_\_\_\_

2. Restricted pushing/pulling of \_\_\_\_\_ lbs.

3. Restricted reaching:  above chest  overhead  away from body

4. Restricted to one-handed duty. No use of:  Right hand  Left hand

5. Restricted  walking  standing  sitting (describe fully)  partial weight bearing (describe fully)  bending  twisting

6. Wear splint at:  All Times  Work  Night (describe fully)

7. DO NOT:  Operate Machinery  Crawl  Kneel  Squat  Drive any Vehicle  Climb  Bend  
 Stoop  Twist

8. FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**III. MEDICAL & REHABILITATION**

A. Is continuing medical treatment needed? NO  YES  If YES, describe fully, including date of next appointment. Supplement with extra pages if needed.

B. Is vocational rehabilitation indicated? (i.e. As a result of the injury, is the employee unable to perform the same occupational duties the employee was performing before the injury?) NO  YES

***I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.***

**I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:**

Employee/Counsel
Address (Number & Street)
City State Zip Code

Employer/Counsel
Address (Number & Street)
City State Zip Code

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of Physician
Address (Number & Street)
City State Zip Code
Telephone Number of Physician
Print or type name of Physician