CC-FORM-5

SEND COPIES TO:
1- Employee/Claimant
1 - All Other Parties of Record

In re claim of:

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS

Full Name of Employee (Claimant)
Employee's Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

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

I. RELEASED FOR WORK?

☐ YES, released to: ☐ Regular Work (date): ☐ Modified Work (date): Give Restrictions (complete Section II)

☐ 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 maintenance 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 work for which the person has previous training or experience?) 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 punishable by imprisonment, a fine or both.

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		

Revised 4-18-18