

	PHYSICIAN'S MEDICAL STATUS REPORT	Document Number:	TTT-HS-FRM-0072
		Division:	QHSE
		Incident Date:	

TITANIUM TUBING TECHNOLOGY LTD. has a policy requiring all employees seeking medical treatment for work related injury, condition of illness to provide this form to their attending physician for completion. The employee should first complete the following authorization to allow the attending physicians to release appropriate medical information to be used in planning modified work in a customized Modified Duties Program.

PART A: AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION – To be completed by employee

This serves an authority to release to my employer, or their agent or representative, any relevant medical records and or information regarding diagnosis, assessment or treatment related to my current, work related injury, condition or illness

Employee Name: _____ Accident Date: _____
Employee Address: _____ Date of Birth: _____

Home Phone #: _____ Work Phone#: _____
Employee Signature: _____ Date: _____

JOB DESCRIPTION: ____ OFFICE ADMINISTRATION ____ LABOUR ____ TRUCK DRIVER ____ EQUIPMENT OPERATOR ____ CREW SUPERVISOR ____ MANAGEMENT

Part B: Medical Information – To be complete by Attending Physician

Titanium Tubing Technology wishes to ensure prompt and safe recovery and rehabilitation of our employee. We have a comprehensive Modified Work Program. Please complete the follow to assist us in developing this employee's Modified Work Plan. If you would like more information prior to completing this please call the HSE & Compliance Manager at 780 872-6978 or the office at 780 872-6978

Date of Treatment: _____ Description of Injury: _____
Description of Accident / Mechanism of Injury: _____
Description of Physical / Objective findings: _____
Test Ordered (X-Rays, Blood Work, etc.): _____
Diagnosis: _____
Physical Treatment (Drugs, Physio, Cast, Crutches, etc): _____
Date Expected to Return to Full Duties: _____

PART C MODIFIED WORK PROGRAM APPROVAL – To be completed by attending Physician.

Please check which of the following work placements is immediately suitable for our employee, or contact our HSE Manager for a customized program

- ☐ **INTERIM WORK PLACEMENT: SEDENTARY**, self-activity (i.e. sitting) no requirement to lift, carry or climb, limb elevation as required.
- ☐ **LIGHT DUTIES:** Standing or sitting with limb elevation as required; Walk from one task to another; Limited lifting, pushing or pulling no greater than 10kg; and no climbing.
- ☐ **MEDIUM DUTIES:** Standing, walking, sitting as required; Limited lifting, carrying, pushing, pulling, no greater than 15kg; and limited lifting
- ☐ **REGULAR DUTIES;** (Limited to no restrictions)

PART D PHYSICIANS IDENTIFICATION, CONTACT INFORMATION & SIGNATURE – To be completed by attending Physician.

Physician's Signature: _____ Date: _____
Physicians Name: _____ Phone: _____
Address: _____ Fax #: _____

Ensure to Scan & Email to HSE Manager and Fax to 1-780-875-5249