I. Employee Information

EMPLOYEE NAME	JOB TITLE
REGION/DEPARTMENT	DATE OF INJURY/ILLNESS

Employee's Limited Release of Medical Information
My signature below indicates my limited release of medical information to my employer, Simon, as requested and as is necessary to assess my ability to safely return to work. I also agree that I will follow through with all of the restrictions prescribed by my doctor, and notify my supervisor of any departure from these restrictions.

_____ _____
EMPLOYEE SIGNATURE DATE

II. Return to Work Information (to be completed by employee's attending physician)

MEDICAL PROFESSIONAL NAME	FACILITY/CLINIC NAME
FACILITY/CLINIC ADDRESS	PHONE

Please provide the following information regarding the employee listed in Section I:

Date of anticipated return to work: _____

Scheduled follow-up appointment date (if applicable): _____

May return to work with no restrictions: ___YES ___NO

May return to work with restrictions/modified duty: ___YES ___NO ___N/A

Work Restrictions/modified duty includes:

Lifting/Carrying:	___N/A	___1-10 lbs	___11-25 lbs	___26-50lbs ___50+ lbs
Bending/Stooping:	___N/A	___0-6 times/hr	___7-10 times/hr	___10+ times/hr
Kneeling:	___N/A	___0-6 times/hr	___7-10 times/hr	___10+ times/hr
Pushing:	___N/A	___10-25 lbs	___26-50 lbs	___50+ lbs
Pulling:	___N/A	___10-25 lbs	___26-50 lbs	___50+ lbs
Climbing:	___N/A	___No ladders	___No stairs	___No ramps
Use of Hands/Arms:	___N/A	___No work using:	___R Hand/Arm	___L Hand/Arm
Use of Legs/Feet:	___N/A	___No work using:	___R Leg/Foot	___L Leg/Foot

(Continued on page 2)

Standing: _____

Sitting: _____

Walking: _____

Overhead Work: _____

Operating Equipment/Vehicles: _____

Has employee been prescribed any medications? ___YES ___NO

If yes, could prescribed medication related to this injury/illness effect employee's work performance or his/her ability to perform his/her job responsibilities in a safe manner, including operation of vehicles, heavy machinery, or other equipment/tools? ___YES ___NO

Please explain:

_____

_____

_____

Additional Comments:

_____

_____

_____ _____

MEDICAL PROFESSIONAL SIGNATURE DATE

FAX COMPLETED FORM TO SIMON'S CONFIDENTIAL FAX: 307-632-3361

FOR QUESTIONS, PLEASE CONTACT HUMAN RESOURCES: 307-635-9005