Workplace Injury Medical Evaluation Form

Employee Information

Name

Employee ID

Department

Job Title

Injury Details

Date of Injury

Time of Injury

Location of Injury

Description of Injury (include body part and nature of injury):

Medical Evaluation

Medical Findings / Examination Results

☐ Fit for Duty ☐ Restricted Duty ☐ Off Work

If restrictions or accommodations are required, specify:

Treatment & Follow-Up

Treatment Provided / Medications Prescribed

Recommended Follow-up (specialist, imaging, time off, etc.)

Provider Information

Medical Provider Name

Title/Position

Signature

Date