

Medical Evaluation Report for Workplace Injury

Employee Information

Name:

Employee ID:

Date of Birth:

Department/Position:

Incident Details

Date of Injury:

Time of Injury:

Location:

Description of Incident:

Medical Evaluation

Date of Evaluation:

Evaluating Medical Professional:

Nature of Injury:

Body Part(s) Affected:

Clinical Findings (objectives, signs, symptoms):

Treatment Provided:

Recommendations

Work Status:

e.g., Fit for work / Restricted duties / Not fit for work

Restrictions/Accommodations:

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Follow-Up Needed:

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Additional Comments:

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Medical Professional Signature

Date