Washburn County
Health and Human Services Department

Jim L. LeDuc, Director

Health and Human Services
Child Support
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Phone: 715-468-4747 Fax: 715-468-4753

ABILITY TO WORK REPORT

Patient Name: _____ DOB: _____

Date of injury/illness: _____

Diagnosis:
_____
_____

Prognosis:
_____
_____

PLEASE COMPLETE THE FORM BY SELECTING THE OPTION(S) THAT APPLY:

____ Patient is PERMANENTLY & TOTALLY DISABLED as of _____ (date)

____ Patient is TEMPORARILY DISABLED and unable to work as of _____ (date) and will be reevaluated on _____ (date)

____ Patient is able to return to work WITHOUT restrictions as of _____ (date)

____ Patient is TEMPORARILY or PARTIALLY DISABILED & has the following work restrictions as

of_____ (date) through _____ (date).

Restrictions are as follows or documentation attached:
_____
_____

Additional Comments:

Medical Provider's Signature: (no stamps please) _____ Phone:_____

Medical Provider's Printed Name: _____ Date: _____