KATHLEEN BABINEAUX BLANCO
LIEUTENANT GOVERNOR

State of Louisiana
OFFICE OF THE LIEUTENANT GOVERNOR
DEPARTMENT OF CULTURE, RECREATION & TOURISM
MANAGEMENT AND FINANCE

PHILLIP J. JONES
SECRETARY

MATTHEW A. JONES
UNDERSECRETARY

HUMAN RESOURCES MEMORANDUM NO. 03-010

January 14, 2003

TO: Lt. Governor, Secretary, Undersecretary, Assistant Secretaries, Deputy Assistant Secretaries, Program Managers

FROM: Mary F. Ginn
Human Resources Director

SUBJECT: New Medical Release Form

The attached Medical Release Form is to be used when an employee has been absent from work on a Worker=s Compensation or FMLA illness or injury and is ready to return. A medical release from an employee=s physician has always been a requirement. However, we are often called upon to write a letter to the physician describing the employee=s job and the physical requirements before the physician is able to make a determination.

We believe this form will consolidate the information that is required by both our department and the employee=s physician on one document and will help supervisors to determine the appropriate course of action upon an employee=s return to work. Supervisors must complete the job title and duties section of the form, including physical requirements, prior to giving the form to the employee for completion.

If you have general questions concerning the form, please call us at (225) 342-0880. If you have questions concerning Worker=s Compensation, please call Gerald Ganey, Safety Director, at (225) 219-9413.

Attachment

Please Post and Circulate

MEDICAL RELEASE FORM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(to be completed by employee)

I, _____, in order to verify my ability to return to duty and perform (or not perform) the duties of my position, do hereby authorize my physician, _____ to release the medical information requested below.

Mail completed document to: Dept. of Culture, Recreation and Tourism
ATTN: Human Resources Director
P. O. Box 94361
Baton Rouge, LA 70804-9361

_____ _____

Employee=s Signature Date

EMPLOYEE=S JOB INFORMATION

(to be completed by supervisor)

Employee_____DOB_____

Job Title_____

Duties_____

_____

_____

PHYSICIANS REVIEW AND STATEMENT

(to be completed by physician)

1. The above referenced employee has been seen by me for a medical condition from_____ through _____.

2. Date of last professional consultation _____

3. Prognosis _____

4. Based on my knowledge of this employee=s medical condition, the employee is:

   ___(a) medically able to competently and safely perform the duties described above and can return to work on a regular basis on _____.

___(b) medically unable to competently and safely perform the assigned duties as described above.

___(c) medically able to return to work on _____ to perform modified duties, including the following restrictions and limitations:

_____

_____

_____

___(d) an updated evaluation, to be conducted on _____, is required before this employee can be permitted to return to work.

5. Additional comments:

_____

_____

_____

Please print physician=s name and address:

_____
Physician=s Name

_____
Address

_____ _____
City/State Telephone #

Certified by:

_____ _____
Physician=s Signature Date