PHYSICIAN STATEMENT/RELEASE

FORM 23-126 REV. 12

Allegheny Energy

COMPLETED BY SUPERVISOR

EMPLOYEE NAME	IMMEDIATE SUPERVISOR

COMPANY ADDRESS

EMPLOYEE WORK LOCATION	SOC. SEC. NO.	POSITION TITLE

WORK SCHEDULE		TYPE WORK PERFORMED			ABNORMAL ENV. CHARACTERISTICS
Days Per Week		☐ Office	☐ Sitting	☐ Standing	☐ Climate/Temperature
Hours Per Day		☐ Heavy Physical	☐ Climbing	☐ Driving	☐ Noise/Vibrations
Average Hours Monthly Overtime		☐ Light Physical	☐ Balance	☐ Twisting	☐ Biological Agents/Infections
		☐ Respiratory protective equip. worn	☐ Bending	☐ Coordination	☐ Airborne Dust/Fumes/Vapors
		☐ Machinery involved, explain:	☐ Walking	☐ Lifting	☐ Chemicals
					☐ Other:

COMPLETED BY EMPLOYEE

Permission is hereby given to Dr. _____ to provide my employer and employer's authorized agents with the information requested below and to orally discuss that information with them.

EMPLOYEE SIGNATURE	DATE

ATTENDING PHYSICIAN STATEMENT

The above-named employee has been under my professional care from _____ to _____

DIAGNOSIS _____

WAS PATIENT HOSPITALIZED	NAME OF HOSPITAL	DATE ADMITTED
◯ Yes ◯ No		

PATIENT HAS BEEN ADVISED TO: (Please check and complete all that are applicable.)

☐ Return to full employment on _____ with no limitations.

☐ Return to employment on _____ with limitations.
(Describe limitations regarding work such as: climbing poles, lifting, carrying, walking, driving, and specify time limit involved.)

☐ Not return to work at this time ☐ Discontinue working ☐ Remain under my professional care

EXPLANATION _____

PHYSICIAN SIGNATURE	DATE	TELEPHONE NUMBER
		( )

OFFICE ADDRESS

NOTE

Employee or physician returns form to:

Allegheny Energy (Medical Office)
800 Cabin Hill Drive
Greensburg, PA 15601-1689

A confidential medical FAX line is also available:
FAX (724) 830-5158

If you have questions or need information, call:
(724) 838-6627