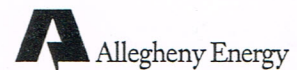


PHYSICIAN STATEMENT/RELEASE

FORM 23-126 REV. 12

**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		<input type="checkbox"/> Office	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Climate/Temperature
Hours Per Day		<input type="checkbox"/> Heavy Physical	<input type="checkbox"/> Climbing	<input type="checkbox"/> Driving	<input type="checkbox"/> Noise/Vibrations
Average Hours Monthly Overtime		<input type="checkbox"/> Light Physical	<input type="checkbox"/> Balance	<input type="checkbox"/> Twisting	<input type="checkbox"/> Biological Agents/Infections
		<input type="checkbox"/> Respiratory protective equip. worn	<input type="checkbox"/> Bending	<input type="checkbox"/> Coordination	<input type="checkbox"/> Airborne Dust/Fumes/Vapors
		<input type="checkbox"/> Machinery involved, explain:	<input type="checkbox"/> Walking	<input type="checkbox"/> Lifting	<input type="checkbox"/> Chemicals
					<input type="checkbox"/> 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
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ATTENDING PHYSICIAN STATEMENT

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

DIAGNOSIS _____

WAS PATIENT HOSPITALIZED <input type="radio"/> Yes <input type="radio"/> No	NAME OF HOSPITAL	DATE ADMITTED
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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