PHYSICIAN STATEMENT/RELEASE
FORM NO. X-4559 (REV. 10-20)

FirstEnergy

COMPLETED BY SUPERVISOR

EMPLOYEE NAME	IMMEDIATE SUPERVISOR
COMPANY ADDRESS	
EMPLOYEE PERSONNEL AREA	SAP NO. / POSITION TITLE

WORK SCHEDULE		TYPE OF 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		☐ 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, to orally discuss that information with them, and to release medical records regarding this absence to Medical Services.

I understand that the release of my health care records is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I am aware that I have the right to revoke this authorization at any time. Revocation must be in writing directed to the Medical Services Department.

It is my intent that this Authorization shall expire one year following the date below unless otherwise revoked by me or someone acting on my behalf. After that time, the above provider shall not release any records unless a new authorization is executed by me.

EMPLOYEE SIGNATURE	BIRTH DATE	DATE SIGNED

ATTENDING PHYSICIAN STATEMENT

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

DIAGNOSTIC CODE:

Was the employee ever restricted from operating a commercial motor vehicle during their absence? ☐ Yes ☐ No

WAS THE PATIENT HOSPITALIZED ☐ Yes ☐ No	NAME OF HOSPITAL	DATE ADMITTED

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 to 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:**	A confidential medical FAX line is also available:	If you have questions or need information, call/email:
	Jamie Marra	234-678-2601	304-203-1642 or jlmarra@firstenergycorp.com