

# CC-FORM-5

**SEND COPIES TO:**

1 - Employee/Claimant  
1 - All Other Parties of Record

**WORKERS' COMPENSATION COMMISSION**  
1915 NORTH STILES AVENUE  
OKLAHOMA CITY, OK 73105

**Revised 12 18 14**

THIS SPACE FOR COMMISSION USE ONLY

In re claim of:

**PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS**

Full Name of Employee (Claimant)
Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

COMMISSION FILE NO.

Date of Injury

Diagnosis

Part of Body

Date of Exam

<b>I.</b>	<b>RELEASED FOR WORK?</b>	<input type="checkbox"/> YES, released to: <input type="checkbox"/> Regular Work (date): <input type="checkbox"/> Modified Work (date): Give Restrictions (complete Section II)
		<input type="checkbox"/> NO, claimant remains temporarily totally disabled.

**II. RESTRICTIONS (check all that apply and describe fully under number 8 below)**☐ **No Restrictions**☐ **Permanent Restrictions**☐ **Temporary Restrictions**

1. \_\_\_ Restricted lifting (maximum weight in pounds) 10\_\_\_ 25\_\_\_ 50\_\_\_ Other\_\_\_ Frequency \_\_\_\_\_
2. \_\_\_ Restricted pushing/pulling of \_\_\_\_\_ lbs.
3. \_\_\_ Restricted reaching: ☐ above chest ☐ overhead ☐ away from body
4. \_\_\_ Restricted to one-handed duty. No use of: ☐ Right hand ☐ Left hand
5. \_\_\_ Restricted ☐ walking ☐ standing ☐ sitting (describe fully) ☐ partial weight bearing (describe fully) ☐ bending ☐ twisting
6. \_\_\_ Wear splint at: ☐ All Times ☐ Work ☐ Night (describe fully)
7. \_\_\_ DO NOT: ☐ Operate Machinery ☐ Crawl ☐ Kneel ☐ Squat ☐ Drive any Vehicle ☐ Climb ☐ Bend  
☐ Stoop ☐ Twist
8. FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:


**III. MEDICAL & REHABILITATION**

- A. Is continuing medical maintenance needed? NO ☐ YES ☐ If YES, describe fully, including date of next appointment. Supplement with extra pages if needed.
- B. Is vocational rehabilitation indicated? (i.e. As a result of the injury, is the employee unable to perform work for which the person has previous training or experience?) NO ☐ YES ☐

***I declare under PENALTY OF PERJURY that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.***

**I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:**

Employee/Counsel
Address (Number & Street)
City State Zip Code

Employer/Counsel
Address (Number & Street)
City State Zip Code

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature of Physician
Address (Number & Street)
City State Zip Code
Telephone Number of Physician
Print or type name of Physician