

CITY OF ST. PETERSBURG

ILLNESS/INJURY REPORT

PATIENT _____
(Printed Name of Employee)

PHYSICIAN'S STATEMENT

I examined the above-named patient on (date) _____ due to the patient's illness or injury which commenced on (date) _____.

Check all that are applicable:

1. _____ Patient is unable to work due to this injury/illness from (date) _____ through (date) _____ for the following reasons: _____

2. _____ Patient may work a light duty assignment, (e.g., office work assignment)
Work Restrictions or comments _____

3. _____ Patient can return to full duty on (date) _____

Was this condition reported to you as job-related? _____

Attending Physician's Signature

Date