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| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | | | | | | | | **PHYSICIAN AUTHORIZATION OF**SUPPLEMENTAL DISABILITY | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Worker: You are responsible for getting this form completed by your physician to continue receiving supplemental disability.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Worker** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |  | | |  | | | | | |  | | | | | | | |
|  | Worker name | | | | | | | | | | | | | |  | | | Date of birth | | | | | |  | | | | | | | | |
|  |  | |  | | |  | | | | | | | | |  | | |  | | | | | | | | | | | | | | |
|  | Date of injury | |  | | | Claim number | | | | | | | | |  | | | Primary insurer | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Definitions:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  **Primary job** means the job at which the injury occurred. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  **Secondary job** means any other job held by the worker at the time of injury. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  **Temporary disability** means wage loss replacement for the primary job. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  **Supplemental disability** means wage loss replacement for the secondary job(s) that exceeds the temporary disability. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Physician** |  | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | |  | | |
|  | Physician’s name (printed) | | | | | | | | | | | | | | | | | | |  | Phone number | | | | | | | | |  | | |
|  |  | | | | | | | | | | | |  | | | |  | | | | | | | | | |  |  | | |  |  | |
|  | Address | | | | | | | | | | | |  | | | | City | | | | | | | | | |  | State | | |  | ZIP |
|  |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Medically**  **stationary?** |  | | | Yes (date): | | | |  | |  | | |  | | | | | | | | | | | | | | | | | | |
|  |  |  | | | No (anticipated date): | | | | |  | | | |  | | | | | | | | | | | | | | | | | | |
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|  |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Worker/patient ability to work:** | | |  | | | Regular work authorized start (date): | | | | | | | | | | | |  | | |  | | | | | | | | | | |
|  |  | | |  | | | Modified work authorized from (date): | | | | | | | | | | | |  | | | through (date, if known): | | | | | | | | | |  |
|  |  | | |  | | | No work authorized from (date): | | | | | | | | | | | |  | | | through (date, if known): | | | | | | | | | |  |
|  |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Restrictions:** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **I certify that these restrictions apply to :** | | | | | | | | | | |  | | | | | **Primary job** | | | | | | | | |  | | | | | | |
|  |  | | | | | | | | | | |  | | | | | **Secondary job** | | | | | | | | |  | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | |  |  | | | | | |  | | | | | |
|  | | | | | | | Physician’s signature | | | | | | | | | | | | | | |  | Date | | | | | |  | | | | | |
| 440-3531 (8/25/DCBS/WCD/WEB) | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |