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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. |
|  |
|  |  |  |
| **Physician**  |       |  |       |  |
|  | Physician’s name (printed) |  | Phone number |  |
|  |       |  |       |  |       |  |       |
|  | Address |  | City |  | State |  | ZIP |
|  |  |  |
|  | **Medically****stationary?** | [ ]  | Yes (date): |       |  |  |
|  |  | [ ]  | No (anticipated date): |       |  |
|  |  |  |
|  |  |  |
|  | **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) |  |