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 Walker, LA
 Office: (225) 380-1720
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Name: _____ Date: _____

Company: _____

Job Title: _____

MEDICAL RECOMMENDATION FORM

I. Examination:	
<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> DOT Driver Examination
<input type="checkbox"/> Hazmat Examination	<input type="checkbox"/> Other:

The following medical recommendation is based on a review of the history, physical examination and any ancillary testing. This recommendations for the specific job title listed above.

II. STATUS	
<input type="checkbox"/> A.	Employable without accommodations
<input type="checkbox"/> B.	Employable without accommodations pending Drug Screen/ X-ray/ Lab Work
<input type="checkbox"/> C.	Employable with accommodations if accommodations are available
<input type="checkbox"/> D.	Employable with accommodations if accommodations are available pending Drug Screen/ X-ray/ Lab Work
<input type="checkbox"/> E.	Medical Hold
<input type="checkbox"/> F.	Does NOT meet job requirements even with accommodations

III. SPECIAL STATUS	
<input type="checkbox"/> A.	Corrective Eye wear is required
<input type="checkbox"/> B.	Hearing Protection is required.
<input type="checkbox"/> C.	Employee is medically qualified to wear a respirator.
<input type="checkbox"/> D.	Employee is medically qualified to wear a self-contained breathing apparatus (SCBA)

I have been informed of all medical findings and authorized the release of the history, physical exam, and test results to the company.

Provider: Physician/Physician Assistant