

Health Remède

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	Date:		
Employee:			
Company:			
Diagnosis:			
Please Specify:	☐ Job Related Illness/Injury		Personal Illness/Injury
Treatment Rendered:	☐ Drug Screen Collected		
	☐ Medication – Over the Counter		
	☐ Prescription Medications		
	☐ First Aid		
	☐ Medical Treatment Beyond First Aid		
	☐ Restricted Duty Beyond First Aid		
May Resume work	wit	h:	☐ Regular Duty
			☐ Restrictions Listed Below
			☐ Off Work
Return Appointment: _			_ Discharged: □ Yes □ No
Referred To:			Phone:

Provider: Physician/Physician Assistant