MEDICAL EVALUATION FORM M-16

MARK THE APPROPRIATE ANSWER BELOW

Sent by Certified # : _____

Patient's name:

Date of Examination of the above patient:

1. What is the patient's diagnosis ?

2. Is the patient suffering from Epilepsy?	YES ☐ NO ☐
If yes,is the Epilepsy under adequate control ?	YES ☐ NO ☐
3. Is the patient suffering from a physical or mental impairment that substantially limits the patient in his/her ability to work or engage in one or more major life activities?	YES ☐ NO ☐
4. What is the patient's prognosis ?	GOOD ☐ BAD ☐ UNCERTAIN ☐
5. Will the patient be incapacitated from work for any period of time? If so, through what dates ?	YES ☐ NO ☐
6. May patient return to full duty at U. S. Postal Service?	YES ☐ NO ☐
7. Will the patient have to work under some form of medical or other limitation?	YES ☐ NO ☐
If so, does patient have the necessary skills as well as physical ability to perform his/her normal USPS job requirements with reasonable accomodations for this above impairment?	YES ☐ NO ☐
Will patient benefit from this accomodation ?	YES ☐ NO ☐
Does patient need accomodation to improve his/her quality of life ?	YES ☐ NO ☐
8. Could patient currently be hazardous to patient's self or others if at work ?	YES ☐ NO ☐
9. Is the patient being treated for the above diagnosis by any hospital or other doctor ?	YES ☐ NO ☐
If yes, has the patient been officially discharged ?	YES ☐ NO ☐
10. Based on your current knowledge, is the patient's above diagnosed medical status related to and aggravated by the patient's employment with the U.S. Postal Service ?	YES ☐ NO ☐
11. Is the patient suffering from a Family Medical Leave Act (FMLA) qualifying serious health condition in duration of more than 3 days?	YES ☐ NO ☐
12. Is above diagnosis a permanent or temporary condition for patient ?	Permanent, unless there is change ☐ Temporary ☐
13. Is working medical care prescribed for the above named patient ?	YES ☐ NO ☐
a. How many days a week should patient work at the straight time rate ?	☐ WITHIN 7 DAYS
b. How many hours a week should patient work at straight time rate ?	NO MORE THAN ☐
c. How many days a week can patient work at some form of overtime rate ?	☐ DAYS A WEEK
d. How many hours a day can patient work at some form of overtime rate ?	☐ HOURS A DAY
14. Is patient being referred to any other physician(s) by you ?	YES ☐ NO ☐
If So, who is this physician(s)?	☐

ADDITIONAL REMARKS: ☐

Information on form M-16 precludes any information on any other form(s) that I sign that appears to conflict with M-16 info or become part of a dispute

_____ ATTENDING PHYSICIAN'S SIGNATURE

_____ ATTENDING PHYSICIAN'S NAME PRINTED

_____ DATE

ATTENDING PHYSICIAN'S ADDRESS: _____

Received by U.S.P.S. Supervisor: _____ Date: _____

FORM CREATED BY DAVE DUNKLE