SUNBELT CONTROLS

Appendix 33-D1
Weekly Off-Work Employee Follow-Up Report

Employee Name—Last, First & Middle Name			Date
Address—Number & Street			Phone No. ( ) –
City	State	Zip Code	Social Security No. – –
Job Title / Department			Title
Gender	Birth Date / /		

Supervisor's Employee Evaluation

Follow-Up Questions	Comments
Is the employee satisfied with level of treatment they have received thus far?	
How does the employee feel about his/her recovery?	
Has there been any change in the employee's prognosis and/or recovery time? *(confirm with medical provider)*	
Is the employee still planning to return to work upon recovery *(pending medical provider's release approval)*?	
If available *(and per medical provider's approval)*, **is the employee interested in returning to work on restricted and/or part-time status performing modified duty(s)?**	
Does the employee have any questions or concerns they would like to address?	

ADDITIONAL COMMENTS

Supervisor Name	Date