Return to: Jefferson County Child Support Agency, 311 S Center Ave., Jefferson WI 53549
childsupport@jeffersoncountywi.gov; Fax: 920-674-7435

ABILITY TO WORK REPORT – JEFFERSON COUNTY CSA

Patient Name: Diagnosis:
Date of Birth:
SSN: Date of injury/illness:

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

1. ____ Patient is PERMANENTLY & TOTALLY DISABLED as of _____(date).

OR

2. ____ Patient is TEMPORARILY, TOTALLY DISABLED as of _____(date) through _____ (date) **AND**

a) On _____ (date), Patient will be reevaluated.
OR
b) Patient has been referred to _____ for further treatment/opinion.
Name / Address / City / State / Phone: _____
_____
_____
_____

OR

3. ____ Patient is PERMANENTLY, PARTIALLY DISABLED & has the following work restrictions as of _____ (date), as follows/attached:

_____
_____
_____
_____

OR

4. ____ Patient is TEMPORARILY, PARTIALLY DISABLED & has the following work restrictions as of _____ (date), as follows/attached:

_____
_____
_____
_____ **AND**
will be reevaluated on _____ (date) OR
will be released to return to work without restrictions on _____ (date).

Medical Provider's Signature (No Stamps): _____ Date: _____
Medical Provider's Printed or Stamped > Name / Address / City / State / Phone: