ConocoPhillips

Employee Health Report

Email completed form to
healthservices@conocophillips.com
OR Fax completed form to
(918) 662-6873

Section 1: Employee Complete (Print)

Employee Name	Job Title	Employee Number
Employee Address, City, State, ZIP	Supervisor Name	Employee Contact Number

First Day of Injury/Illness	First Day Missed Work	Last Day Missed Work	Work Related	Supervisor Notified
			☐ Yes ☐ No	☐ Yes ☐ No

I hereby authorize the undersigned Physician, Physician Assistant, or Nurse Practitioner to release or to discuss with a ConocoPhillips Case Manager, any pertinent information regarding this injury or illness (continued on next page).

Employee Signature	Date
X	

Section 2: Attention Physician, Physician Assistant, or Nurse Practitioner: ConocoPhillips promotes a TRANSITIONAL DUTY PROGRAM. Please complete ALL of the information below concerning the employee's work status.

Date of Visit	Diagnosis / Surgery (when and what type)	ICD 10 Code
/ /		

Overnight Hospital Stay	Current Medications or Other Treatment Plan (i.e., Counseling, physical therapy) AND Frequency
☐ Yes ☐ No	

Complications

Prognosis

Date of Next Visit	Has maximum medical improvement been attained?	Date maximum medical improvement was attained
/ /	☐ Yes ☐ No	/ /

Select the Disposition ⇒

☐ Regular duty, release with no restrictions on (date) _____

☐ If employee cannot perform regular duty, please complete section below

If Modified Duty, Please Describe Below

Start Date of Restrictions	End Date of Restrictions	Duration of the restrictions are
/ /	/ /	☐ Permanent ☐ Temporary ☐ Unknown

1. Is there a limitation on lifting? ☐ **Yes** ☐ **No** **Please describe:**

2. Is there a limitation on sitting/standing/walking? ☐ **Yes** ☐ **No** **Please describe:**

3. Is there a limitation on grasping? ☐ **Yes** ☐ **No** **Please describe:**

4. Is there a limitation on climbing/kneeling/bending? ☐ **Yes** ☐ **No** **Please describe:**

5. Is there a limitation on pushing/pulling/reaching above shoulders? ☐ **Yes** ☐ **No** **Please describe:**

6. Can employee operate a motor vehicle? ☐ **Yes** ☐ **No**

7. Can employee operate heavy machinery? ☐ **Yes** ☐ **No**

8. Other

☐ Must wear splint, cast, boot, crutches, other _____ ☐ At work ☐ At all times

9. Are there any limitations on wearing respirator? ☐ **Yes** ☐ **No** **Please describe:**

Work Schedule

☐ Able to work full shifts

Is there any limitation on working regular shift? ☐ **Yes** ☐ **No** **Please describe:**

Date of Anticipated Full Recovery	Additional Comments
/ /	

Signature and Contact Information is Required

Name of Physician / Physician Assistant / Nurse Practitioner - Print	Address
Name of Physician / Physician Assistant / Nurse Practitioner - Signature X	Email Address
Date / Phone No.	

Please return completed form today by email, fax or mail to:

ConocoPhillips Company
Health Services
PO Box 5555
Bartlesville, OK 74005
ph: 877-812-7547
email: healthservices@conocophillips.com
fax: 918-662-6873

Additional Consent Information

I understand that this authorization is voluntary and that a ConocoPhillips Licensed Health Care Professional includes a physician, nurse, nurse practitioner, case manager physician assistant, or employee assistance program (EAP) counselor. I also understand failure to provide authorization could affect my eligibility for ConocoPhillips Short Term Disability benefits. This authorization will remain in effect until I return to work on the basis of full duty, but not longer than 60 days from the date of my signature.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation notice.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons to organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

Use of email encryption (i.e., Office 365 email encryption, Zixmail, etc.) is encouraged. This helps to ensure only intended recipients can open and view email and its contents.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.