

**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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Supervisor Notified <input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby authorize the undersigned physician, Licensed Health Care Professional (LHCP) or Behavioral Health Care Professional to release or to discuss with a ConocoPhillips Licensed Health Care Professional, any pertinent information regarding this injury or illness (continued on next page).					
Employee Signature <b>X</b>					Date / /

**Section 2: Attention Physician, Licensed Health Care Professional or Behavioral Health Care Professional: 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications or Other Treatment Plan (i.e., Counseling, physical therapy) AND Frequency	
Complications		
Prognosis		
Date of Next Visit / /	Has maximum medical improvement been attained? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date maximum medical improvement was attained / /
<div style="display: flex; align-items: center;"> <div style="border: 1px solid red; padding: 2px; margin-right: 10px;"><b>Select the Disposition</b></div> <div style="font-size: 2em; margin-right: 10px;">➔</div> <div> <input type="checkbox"/> Regular duty, release with no restrictions on (date) _____  <input type="checkbox"/> If employee cannot perform regular duty, please complete section below         </div> </div>		

**If Modified Duty, Please Describe Below**

Start Date of Restrictions / /	End Date of Restrictions / /	Duration of the restrictions are <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Unknown
1. Is there a limitation on lifting? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
2. Is there a limitation on sitting/standing/walking? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
3. Is there a limitation on grasping? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
4. Is there a limitation on climbing/kneeling/bending? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
5. Is there a limitation on pushing/pulling/reaching above shoulders? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
6. Can employee operate a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Can employee operate heavy machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Other <input type="checkbox"/> Must wear splint, cast, boot, crutches, other _____ <input type="checkbox"/> At work <input type="checkbox"/> At all times		
9. Are there any limitations on wearing respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
<b>Work Schedule</b> <input type="checkbox"/> Able to work full shifts Is there any limitation on working regular shift? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:		
Date of Anticipated Full Recovery / /	Additional Comments	

**Signature and Contact Information is Required**

Name of Physician / LHCP / or Behavioral Health Care Professional - Print		Address
Physician / LHCP / or Behavioral Health Care Professional Signature <b>X</b>		
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.