TREATMENT PROVIDER WORK RESTRICTIONS EVALUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD SUPPORT
SFN 1584 (10-2024)

Clear Fields

TREATMENT PROVIDER: The requested information is necessary to determine the patient's ability to perform employment-related functions. Please complete and sign this form.

Patient Name	Date of Appointment

Does the patient have any restrictions or limitations that affect their ability to be employed?

- ☐ No
- ☐ Yes, explain:

Can the patient return to work?

- ☐ No
- ☐ Yes - Date patient can return to work: _____ Number of hours patient can work per day: _____
  - ☐ Without work restrictions.
  - ☐ With the following work restrictions/limitations. Explain:

If the patient is unable to return to former employment, can they work in any capacity?

- ☐ No
- ☐ Yes - Number of hours per day: _____
  - ☐ Without work restrictions.
  - ☐ With the following work restrictions/limitations. Explain:

Recommended medical/physical/mental health treatment or therapy and anticipated length:

The above restrictions are in effect until	Re-evaluation Date

Treatment Provider's Name (printed)	Specialty/Area of Practice
Treatment Provider's Signature	Date

Treatment Facility Name			
Address	City	State	ZIP Code

By signing here, I authorize the release of this form to North Dakota Child Support

Patient's Signature	Date

Once your treatment provider has completed and signed this form, return immediately to North Dakota Child Support using the address, fax, or email provided below.

Mail to:
North Dakota Child Support
PO Box 7190
Bismarck ND 58507-7190

Fax: 701-328-5425

Email: childsupport@nd.gov