|  |  |  |
| --- | --- | --- |
|  |  | **EMPLOYEE'S RETURN TO** |
| **Human Resources** |  | **WORK FORM** |
| **1016 University Circle** |  | Must be completed legibly by physician |
| **Ogden, UT 84408-1016** |  |  |
|  |
| **801-626-6032 Fax: 801-626-6925** |  |  |
|  |  |  |



Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of Treatment:

History:

Name(s) of other physician(s) or medical providers who have served on case:

Diagnosis:

Treatment (Proposed or completed):

Medication(s):

Prognosis:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | First day off work: | | | |  | | | | | |  |  |  |  |  | **Estimated** return to work date: | | | | | | |  |  |  |
|  | Actual Return to Work **without** restrictions: | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Return to work **with** reduced schedule: | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Number of hours per day: | | | | | | | | | | |  |  | Number of days per week: | | | | | | | |  |  |
|  |  |  | Beginning: | | | | | | |  |  |  |  |  |  | Ending: |  | |  |  |  |  |  |  |  |
|  |  | Return to work with the following restrictions: | | | | | | | | | | | | Beginning: |  |  |  |  | Ending: | | |  | |  |  |
|  |  |  |  |  |  |  |
|  |  | Lifting (weight) | | | | | | | | | 0-10 lbs. | | | 11-25 lbs. | | 26-40 lbs. | | |  | 41-50 lbs. | | | | over 50 lbs. | |
|  |  |  |
|  |  | Lifting | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | From Floor | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  | From waist level | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  | Over the shoulder/head | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  | Pushing/pulling (weight) | | | | | | | | | 0-10 lbs. | | | 11-25 lbs. | | 26-40 lbs. | | |  | 41-50 lbs. | | | | over 50 lbs. | |
|  |  |  |
|  |  | Pushing/pulling frequency | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Standing | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Sitting | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Walking | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Climbing | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Bending 18”from body | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | From shoulder level | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | Over the head | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  | Kneeling/Squatting | | | | | | | | | 25% |  |  | 50% | | 75% | |  | 100% | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  | No operating moving machinery | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | No Driving | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Additional instruction: | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  | |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Date of next office visit: | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Physicians Name: | | | | | | | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | City, State, Zip: | |  |  | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Telephone Number: | | | | | | | | | |  |  |  |  |  | Fax Number: | | |  |  |  |  |  |  |  |
|  |  | | | | |  | |  | | |  |  |  |  |  |  |  |  |  |  | | | |  |  |
|  | Physician’s Signature: | | | | | | | | | |  |  |  |  |  |  |  |  | Date: | | | | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |