ATTN: Employee
This form MUST be submitted to Employee Services **(Attn: Benefits)** ***BEFORE*** you return to employment following an extended medical leave of absence OR a work-related injury requiring medical attention

Middleton-Cross Plains Area School District

Inspire ★ Challenge ★ Empower

ATTN: Physician/Provider
Please complete this form and provide to employee OR fax
ATTN: BENEFITS
608-836-3571

Work Release/Physical Capacities Form

For physician's completion

Employee Name: _____ Evaluation Date: _____

If treating for a work-related injury: Date of Injury _____

Part(s) of body affected _____ Right ☐ Left ☐

The above-referenced employee has been evaluated and may return to:

Regular work on: _____ (Date) OR Modified work on: _____ (Date)

OR

Is not released, anticipated release date: _____

ITEM	PERCENT OF DAY (Based on 8 hour day)					Restrictions And Recommendations
	0	1-5	6-33	34-66	67-100	
	Never	Rare	Occasionally	Frequently	Constantly	
Lifting (lbs)						
Floor to Waist Lift						
Waist to Shoulder Lift						
Horizontal Lift						
Bilateral Push force						
Bilateral Pull force						
Two hand carry						
Left hand carry						
Right hand carry						
Standing Tolerance						
Sitting Tolerance						

Note other specific restrictions: (example: repetitive motion, reaching, grasping, dry environment, etc.)

_____

_____

_____

These restrictions are: ☐ Permanent ☐ Temporary, expected to last _____ weeks.

Next appointment date: _____.

_____ _____

(Health Care Provider's Signature) (Examiner's Name)

Physician's contact information: _____

Practice name and address Phone, Fax