

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	Date:
Physician's Name:	Telephone #:

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _____ (Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _____ (Date) WITH THE FOLLOWING RESTRICTIONS:

Check applicable boxes and provide limitations/restrictions.	
<input type="checkbox"/> Lifting (Max weight in lbs) _____ lbs.	<input type="checkbox"/> Walking _____ hours per day
<input type="checkbox"/> Repetitive Lifting _____ lbs.	<input type="checkbox"/> Standing _____ hours per day
<input type="checkbox"/> Carrying _____ lbs.	<input type="checkbox"/> Sitting _____ hours per day
<input type="checkbox"/> Pushing/pulling _____ lbs.	<input type="checkbox"/> Crawling _____ hours per day
<input type="checkbox"/> Pinching/Gripping _____ lbs.	<input type="checkbox"/> Kneeling _____ hours per day
<input type="checkbox"/> Reaching over head	<input type="checkbox"/> Squatting _____ hours per day
<input type="checkbox"/> Reaching away from body	<input type="checkbox"/> Climbing _____ hours per day
<input type="checkbox"/> Repetitive Motion Restrictions:	
<input type="checkbox"/> Other Restrictions:	
These limitations/restrictions are:	<input type="checkbox"/> Temporary limitations/restrictions through _____. <input type="checkbox"/> Permanent limitations/restrictions

IF THE ABOVE RESTRICTION CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK.

My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's ability to perform the job duties.

Physician's Name (Please Print):			
Physician's Signature:		Date:	

I AGREE THAT:

I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:		Date:	
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