Return to Work Form

To be completed by healthcare provider prior to returning to work.

________________________ has been treated by me for __________________________
(Patient) (Condition)

I have examined the Patient named above and reviewed the Patient's job description, if provided. I certify that in accordance with this patient's physical capability (check all that apply)

Restrictions

Patient may resume work immediately, no restrictions
Patient may resume work immediately with the following restrictions:
Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
Light work (lifting less than 20 lbs.)
Medium work (lifting less than 50 lbs.)
Heavy work (lifting less than 100 lbs.)
Other*:____
Other*:____

**If "Other" is selected, on a separate sheet of paper address the details of the restriction, the particular duties which are affected, why they are affected, and any accommodations which would allow the employee to perform the duties.*

Hours/Shifts

He/She is released to work
Hours per day: ____________
His/her normal shift
He/She may return to work at full duty on _______________(date)
He/She has a return appointment on ___________ (date) at ________(time)

Other Medically Significant Information the Employer Should Know:

____
____
____
____

________________________________ ______________________________
Healthcare Provider's Signature Date

________________________________ ______________________________
Printed Name of Healthcare Provider Telephone Number

____
________________________________ ________________________
Address Type of Practice