**Physician’s Release to Return to Work Form**

|  |  |
| --- | --- |
| Employee Name: | Date:  |
| Physician’s Name: | Telephone # |

**To be completed by Physician**

After reviewing the attached job description and the specific duties within the job description, please complete either (A) or (B), then sign and date below.

1. The above named employee has been released by the above named physician as eligible to return to Full Duty as of ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date) with NO RESTRICTIONS.
2. The above named employee has been released by the above named physician to return to work on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date) with the following RESTRICTIONS through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)

|  |
| --- |
| Check applicable boxes and provide the limitations/restrictions. (Max weight in lbs) |
| [ ]  Lifting \_\_\_\_\_\_\_lbs.  | [ ]  Walking \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Repetitive Lifting ­­­­­­­­­­­­­­\_\_\_\_\_\_\_lbs. | [ ]  Standing \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Carrying \_\_\_\_\_\_\_ lbs. | [ ]  Sitting \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Pushing/pulling \_\_\_\_\_\_\_lbs.  | [ ]  Crawling \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Pinching/Gripping \_\_\_\_\_\_\_lbs. | [ ]  Kneeling \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Reaching over head | [ ]  Squatting \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Reaching away from body | [ ]  Climbing \_\_\_\_\_\_\_\_\_ hours per day |
| [ ]  Repetitive Motion Restrictions:  |  |
| [ ]  Other Restrictions:  |  |
| These limitations/restrictions are:[ ]  Temporary limitations/restrictions[ ]  Permanent limitations/restrictions  |

**If the above restriction requires modified duty and such duty is not available, it is assumed that the employee will be sent home instead of returning 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 my findings are based on my medical assessment of this employee’s physical and mental capabilities as compared to the essential functions of the job.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Physician’s Name (Please Print) Date Physician’s Signature

**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 Signature Date
 10/23/2015