The University of New Mexico

1 UNM MSC 10-5550, Albuquerque NM 87131-0001 | Ph: 272-8043 Fax 272-8044 | Email: EOHS@salud.unm.edu

Return to Work Form

Patient Name: _____**Date**:_____

Diagnosis: _____

ONE OF THE FOLLOWING THREE BOXES MUST BE COMPLETED ON RETURN TO WORK STATUS:

☐ **Return to work full duty with no restrictions on this date:_____ (form completed please sign below)**

☐ **Unable to return to work until next evaluation on this date:_____ (form completed please sign below)**

☐ **Able to return to work with the restrictions MARKED IN THE BOXES BELOW**

Lifting Restrictions:
Do not lift more than
☐ No Restrictions
☐ 10 lbs.
☐ 20 lbs
☐ 30 lbs
☐ 50 lbs
☐ Other: _____

Push/Pulling Restrictions:
Do not push/pull more than:
☐ No Restrictions
☐ 10 lbs.
☐ 30 lbs
☐ 50 lbs
☐ 100 lbs
☐ Other: _____

☐ **Limit standing to _____minutes/hour (sitting activities intended when not standing)**

☐ **Work hours limited to _____hours per shift**

Functional Limitations:	**The Patient can perform them:**			
	Unable	**2-4 hrs**	**4-8 hrs**	**6-10 hrs**
Lifting above shoulders	☐	☐	☐	☐
Lifting from below knees	☐	☐	☐	☐
Twisting and repetitive bending at the waist	☐	☐	☐	☐
Climbing ladders/stairs/stepstools	☐	☐	☐	☐
Squatting, kneeling, crawling	☐	☐	☐	☐
Keyboard use (intermittent over the work day)	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Other Instructions and/or Limitations:_____
_____
_____
_____
_____

Contact telephone number: _____
Medical provider name(print):_____

Medical provider signature: _____Date:_____