State of Oklahoma
Workers' Compensation Return to Work Form

Employee's Name: _____ Appt. Date: _____

SSN: _____ Date of Injury: _____ Employer: _____

Brief diagnosis of injury/illness: _____

RETURN TO WORK STATUS

Release: (check only one)

1. ☐ Patient is unable to return to work.
2. ☐ **Full Duty Release**: employee has reached maximum medical improvement (MMI) and is released from active medical care.
3. ☐ **Full Duty Release without Temporary restrictions:** employee is able to work full duty without restrictions, but is not released from active medical care.
4. ☐ **Light Duty Release with Temporary Restrictions**: employee has NOT reached (MMI) and can return to Light Duty Work with the following temporary restrictions: (COMPLETE RESTRICTIONS SECTION)
5. ☐ Will medication use prohibit driving or operation of heavy equipment? Yes ☐ NO ☐

Restrictions: (check all that apply and fully describe below)

☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

1. ☐ Restricted lifting/carrying (maximum weight in pounds) _____ other _____ frequency _____
2. ☐ Restricted pushing/pulling of _____ lbs.
3. ☐ Restricted reaching: above chest _____ overhead _____ away from body _____ other _____
4. ☐ Restricted to one-handed duty. No use of: right hand _____ left hand _____
5. ☐ Restricted: walking ☐ standing ☐ sitting (describe) _____ partial wt bearing (describe)_____
6. ☐ Wear splint at: all times ☐ work ☐ at night (describe) _____
7. ☐ No more than_____repetitive movements per ☐ day or ☐hour of :
   Hand Grasp L☐R ☐ Wrist L ☐R ☐ Elbow Flexion L ☐R ☐ Shoulder L ☐ R ☐ Foot L ☐ R ☐
   ☐ Torso Flexion
8. ☐ DO NOT: Operate Machinery ☐ Crawl ☐ Kneel ☐ Squat ☐
   Drive any vehicle ☐ Climb ☐ Bend ☐ Stoop ☐
9. ☐ Fully describe restrictions (i.e. duration, nature of limitation, etc.) add extra pages if needed:
   _____

Patient requires follow up treatment on: Date: _____ Time: _____

Medications: _____

Physician's notes: _____

Physician's Signature: _____ Date: _____

Address: _____