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**RETURN TO WORK – MEDICAL RELEASE**

***Section I:***

**EMPLOYEE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of Injury**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK ONE OF THE FOLLOWING**

**Employee may return to work:**

 **A.\_\_\_\_\_ Without restrictions on** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Date)

 **B. \_\_\_\_\_ Less than full schedule,** from the time period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Indicate specific dates or span of time)

 Number of hours per day \_\_\_\_\_\_\_\_\_, Release Date to Return Full Schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **C. \_\_\_\_\_ With these restrictions (list below),** from the time period \_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_ (indicate specific dates or span of time)

 with Full Medical Release Effective: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESTRICTIONS**

If the employee’s ability to perform any of the following activities is limited by his/her condition, please describe the extent of the limitation and the expected duration.

|  |  |  |
| --- | --- | --- |
| **Restriction**  |  **Limitation** | **Expected Duration** |
| Standing |  |  |
| Walking |  |  |
| Sitting |  |  |
| Kneeling |  |  |
| Crawling |  |  |
| Climbing |  |  |
| Lifting/Carrying/Weight Limitation |  |  |
| Reaching/working overhead |  |  |
| Pushing/Pulling |  |  |
| Driving |  |  |
| Keyboard use/Repetitive hand motion |  |  |

List any other restrictions or limitations not listed above (i.e. including any medication side effect implications):

Is there assistance that would enable employee to return to work? \_\_\_\_No \_\_\_ Yes. If yes, please explain:

***Section II: SIGNATURE OF HEALTH CARE PROVIDER***

**SIGNATURE OF HEALTH CARE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF HEALTH CARE PROVIDER (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICE PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OFFICE FAX # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_