RETURN TO WORK - EMPLOYEE WORK RESTRICTION/AUTHORIZATION

Must be completed and submitted to HR prior to return to work.

Patient Name: _____

Current Job: _____

Physician Name (please print): _____
Phone: _____ Fax: _____

Date you saw patient: ___-___-____ Time In: _____ Injury Date: ____-____-____

Full Time☐	2nd shift☐	Mon ☐	Fri.☐
Part Time☐	1st shift☐	Sun.☐	Thurs ☐
Seasonal ☐	3rd shift ☐	Tues ☐	Sat☐
Temporary ☐	Swing ☐	Wed ☐	

Next scheduled work day ____ Shift _____
Shift Supervisor: _____

Patient Description of Injury:_____
_____

Diagnosis: _____
_____

Treatment:_____

Prescription strength meds orders ☐ Yes ☐ No
Meds: _____

Plan: _____

Notice: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other entities covered by GINA Title II from requesting or requiring genetic information from an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic service and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

DISPOSITION:
1. ☐ Patient is unable to work at this time.
2. ☐ Recommend his/her return to work with no limitations on (DATE): _____
3. ☐ He/She may return (DATE) _____ with a daily time limitation of _____ and/or with the following limitations until _____ or until re-evaluation on _____.

CHECK ONLY AS RELATES TO ABOVE CONDITION

☐ SEDENTARY WORK. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ LIGHT WORK. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arms and/or leg controls.

☐ LIGHT MEDIUM WORK. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ MEDIUM WORK. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ LIGHT HEAVY WORK. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ HEAVY WORK. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

N=Never/Not Able F=Frequent up to 30x/hr.
O=Occasional up to 4 times/hr. C=Constant over 30x/hr.
Specify Restrictions for 24 day

	N	O	F	C			
Sitting/Driving					Lab Work	Yes __	No __
Standing/Walking							
Climbing					X - Rays	Yes __	No __
Bending							
Kneeling/Squatting/Crawling							
					R	L	BIL
Reaching-Horiz./push-pull							
Reaching-Vert./above shoulder							
Gross Handling							
Finger Manipulation							
Single Grasping							
Repetitive Foot Movement							

OTHER INSTRUCTIONS AND/OR LIMITATIONS:

SCHEDULED APPOINTMENTS:

☐ Referral ☐ Clinic _____ Date: _____ Time: _____

SCHEDULED APPOINTMENTS:

☐ Referral ☐ Clinic _____ Date: _____ Time: _____

Time Out: _____ ☐ Called Employer Date _____Signature _____

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified on this form to my employer or his representative.

PATIENT'S SIGNATURE Date PHYSICIAN'S SIGNATURE Date

_____ _____