PHYSICIAN’S RELEASE TO RETURN TO WORK FORM

Employee’s Name: __________________________ Date: __________________________

Physician’s Name: __________________________ Telephone #: __________________________

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _______________(Date) with NO RESTRICTIONS.

(B) 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 limitations/restrictions.

☐ Lifting (Max weight in lbs) ___________ 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 CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN 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 that my findings are based on my medical assessment of this employee’s physical capabilities as compared to the essential functions of the job.

Physician’s Name (Please Print): __________________________

Physician’s Signature: __________________________ Date: __________________________

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’s Signature: __________________________ Date: __________________________