Return-To-Work Program

Patient/Employee:______________________________ Date of Injury: _____________

Please Select One of the Following:

☐ Worker Released to Regular Job Duties (NO RESTRICTIONS) Date Released:__________

☐ Worker Released for TEMPORARY ALTERNATE ASSIGNMENTS Date Released:__________

Total Number of Hours Employee May Work: ______________________________

TEMPORARY RESTRICTIONS

Note: On terms of an eight hour work day: *Limited* (0-1 hour), *Occasionally* equals 1%-25% (1-2 hours), *Frequently* equals 26%-50% (3-4 hours), *Repeatedly* equals 51%-75% (5-6 hours) and *Continuously* equals 76%-100% (7+ hours). Not Restricted (NR).

Please Circle/Check the Appropriate Choice.

	Number of Hours									
Sit	0	1	2	3	4	5	6	7	8	NR
Stand	0	1	2	3	4	5	6	7	8	NR
Walk	0	1	2	3	4	5	6	7	8	NR

Employee can alternately sit/stand every ______ hours.

	Limited	Occasionally	Frequently	Repetitively	Continuously
Hand/Wrist Work	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Kneel	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐	☐
Lifting 21-50 lbs.	☐	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐	☐
Ability to operate machinery	☐	☐	☐	☐	☐

Comments:

Ability to operate motor vehicle ☐ Yes ☐ No Comments:

☐ Time Loss Authorized – Because of objective findings, worker should remain off work.

Projected date employee can perform temporary alternate work. Date: ______________

Projected date employee can return to full duties. Date: ______________

Physician Comments

Is the patient involved in treatment and/or medication that might affect their ability to work safely in any capacity?

___No ___ Yes – Please explain: ____

Will the employee be required to use any devices or braces? __ No __ Yes – Please explain ____________

Additional Comments: ____

______________________________ ____________________

Physician's Signature Date