

PHYSICIAN'S REPORT / RETURN TO WORK

Patient's Name: _____ Social Security #: _____

Dear Doctor:

Please provide the following information related to this injury/illness. This will assist us in returning our employee to work. Our company has an extensive and comprehensive Return To Work program for the injured/ill employee.

1. Employee may return to normal work duties at once.

2. Employee may return with the following restrictions:

Hours/Day: No restrictions 8 hours 6 hours 4 hours Other _____

Days/Week: No restrictions 5 days 4 days 3 days Other _____

Lifting: No restrictions 40 lbs 30 lbs 20 lbs 10 lbs
 Other _____

Stand/Walk: No restrictions 1-4 hours 4-6 hours 6-8 hours Other _____

Sit: No restrictions 1-3 hours 3-5 hours 5-8 hours Other _____

Drive: No restrictions 1-3 hours 3-5 hours 5-8 hours Other _____

Patient may use hand(s) for repetitive:

Single Grasping Pushing & Pulling Fine Manipulation
 Right Hand Left Hand

Patient may use foot/feet for repetitive movement as in operating foot/feet controls: Yes No

Patient may:

	Not At All	Occasionally	Frequently
(a) Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

No lifting above shoulder level.

Other (please specify): _____

Length of restrictions: Resume regular duties after _____ days, OR
Employee will be re-evaluated on (date) _____.

3. The employee is totally incapacitated at this time. Employee will be re-evaluated on (date) _____.

Physician's Signature

Date

PATIENTS AUTHORIZATION TO RELEASE INFORMATION

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 above to my employer or his representative.

Patient's Signature

Date