

## Return to Work Form

*To be completed by healthcare provider prior to returning to work.*

\_\_\_\_\_ has been treated by me for \_\_\_\_\_  
(Patient) (Condition)

I have examined the Patient named above and reviewed the Patient's job description, if provided. I certify that in accordance with this patient's physical capability (check all that apply)

### **Restrictions**

- ☐ Patient may resume work immediately, no restrictions
- ☐ Patient may resume work immediately with the following restrictions:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
  - ☐ Light work (lifting less than 20 lbs.)
  - ☐ Medium work (lifting less than 50 lbs.)
  - ☐ Heavy work (lifting less than 100 lbs.)
  - ☐ Other\*: \_\_\_\_\_
  - ☐ Other\*: \_\_\_\_\_

*\*If "Other" is selected, on a separate sheet of paper address the details of the restriction, the particular duties which are affected, why they are affected, and any accommodations which would allow the employee to perform the duties.*

### **Hours/Shifts**

- ☐ He/She is released to work
  - ☐ Hours per day: \_\_\_\_\_
  - ☐ His/her normal shift
- ☐ He/She may return to work at full duty on \_\_\_\_\_ (date)
- ☐ He/She has a return appointment on \_\_\_\_\_ (date) at \_\_\_\_\_ (time)

### **Other Medically Significant Information the Employer Should Know:**

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\_\_\_\_\_  
Healthcare Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Healthcare Provider

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Type of Practice