

RELEASE TO RETURN TO WORK

Name of worker _____	
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Please complete the following information and return with the injured employee.

1. Is the worker medically stationary? Yes No Date _____
 Next scheduled appointment date _____

2. Worker is released to:
 full duty without limitations Date _____ (Do not complete lines 3 through 11. Sign below.)
 modified duty from (date) _____ through (date) _____ (specify limitations below.)
 modified hours — specify _____ from (date) _____ through (date) _____

	Hours: No limitations	1	2	3	4	5	6	7	8
3. In an eight-hour workday, worker can stand/walk a total of	<input type="checkbox"/>								
4. At one time, worker can stand/walk	<input type="checkbox"/>								
5. In an eight-hour workday, worker can sit a total of	<input type="checkbox"/>								
6. At one time, worker can sit	<input type="checkbox"/>								

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100
Occasionally	<input type="checkbox"/>																				
Frequently	<input type="checkbox"/>																				

8. Worker can use hands for repetitive:

	Right		Left	
a. Fine manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant hand
b. Pushing and pulling	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left
c. Simple grasping	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Keyboarding	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): Yes No

	Continuous 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Stoop/bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of physician _____	Physician's typed name _____	Date _____
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