Doctor's Name and Address Info

RETURN TO WORK RECOMMENDATIONS AND EMPLOYEE'S JOB DUTIES

INSTRUCTIONS: This form shall be used to describe the employee's job duties when returning to work from a job related injury.
Diagnosis:

EMPLOYEE NAME: (LAST) (FIRST) (M.I.)	CLAIM #:
EMPLOYER NAME: JOB ADDRESS:	
JOB TITLE:	HRS. WORKED PER DAY: / HRS. WORKED PER WEEK:

I saw and treated this patient on _____

The patient may return to work with no limitations on:

☐ The patient may return to work capable of performing the degree of work checked below with the following limitations:

The patient may return to work capable of performing the degree and frequency of activity checked below:

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3–6 hours	CONSTANTLY 6–8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right_ Left_				
Repetitive use of hands				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				

	LIFTING					CARRYING				
	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Height	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Distance
0–10 lbs.										
11–25 lbs.										
26–50 lbs.										
51–75 lbs.										
76–100 lbs.										
100+ lbs.										

Other Instructions and/or Limitations _____

_____

The patient is restricted from performing the following:

	YES	NO	
a. Driving cars, trucks, forklifts and other equipment?	☐	☐	_____
b. Working around equipment and machinery?	☐	☐	_____
c. Walking on uneven ground?	☐	☐	_____
d. Exposure to excessive noise?	☐	☐	_____
e. Exposure to extremes in temperature, humidity or wetness?	☐	☐	_____
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	_____
g. Working at heights?	☐	☐	_____
h. Operation of foot controls or repetitive foot movement?	☐	☐	_____
i. Use of special visual or auditory protective equipment?	☐	☐	_____
j. Working with bio-hazards such as: bloodborne pathogens, sewage, hospital waste, etc.	☐	☐	_____

Other Instructions and/or Limitations

These restrictions are in effect until the patient is re-evaluated on

Doctor's Signature	Date