# Return to Work Form

**Name:** _____ **Date of Injury:** _____

**Employer:** _____ **Diagnosis:**_____

**Please be advised that above named patient may return to work today.**

❑ Full Duty ❑ Limited Duty (See restrictions below) ❑ The above named patient may not return to work until reevaluation
❑ The above named patient may not return to work today, but may return to full duty on _____
❑ The above named patient may not return to work today, but may return to limited duty on _____

**RETURN TO WORK STATUS** **Employee able to return to work with the following restrictions:**

❑ **Sedentary** Maximum lifting and-or carrying of up to 10 pounds; walking, and standing occasionally
❑ **Light** Maximum lifting of up to 20 pounds with frequent lifting/carrying of up to 10 pounds or a negligible amount; significant walking or standing may be required or may involve sitting with a degree of pushing and pulling
❑ **Medium** Maximum lifting of up to 50 pounds with frequent lifting/carrying of up to 25 pounds; frequent standing/walking
❑ **Heavy** Maximum lifting of up to 100 pounds with frequent lifting/carrying of up to 50 pounds; frequent standing/walking
❑ **Very Heavy** Lifting objects more than 100 pounds; frequent lifting carrying of 50 pounds or more; frequent standing and walking

In a shift, employee is able to: ❑ No restrictions on these tasks

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sit: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 hours/day | ❑ Continuously | ❑ With Breaks |
| Stand: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 hours/day | ❑ Continuously | ❑ With Breaks |
| Walk: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 hours/day | ❑ Continuously | ❑ With Breaks |

❑ No Lift/carry over _____lbs
❑ No Push/pull over _____lbs
❑ No use Right/Left foot
❑ No Extreme temperatures
❑ No overhead work ❑ No bending ❑ No Climbing ❑ No Crawling
❑ No Twisting ❑ No Kneeling ❑ No Squatting
❑ May drive up to ____hrs/day ❑ May drive standard shift ❑ May drive automatic shift ❑ No driving
❑ Other:

❑ May use Right/Left hand for fine manipulation
❑ May use Right/Left hand for grasping
❑ No use Right/Left hand
❑ No direct patient care

_____
_____

**Diagnostic Procedures**

❑ **MRI** ❑ **CT scans** ❑ **EMG/NCV** ❑ **Bone Scan** ❑ **Other:**_____

**Treatment Plan**

❑ **PT/OT** ❑ **Medication** ❑ **Injection** ❑ **Other:** _____
❑ **Splint** ❑ **Brace** ❑ **Ambulatory Assistive Device:** _____

**Follow-up Care**

**Next appointment date:**_____ **Time:**_____ ❑ **PRN**

**Physician Signature:**_____ **Date:**_____

**Patient Signature:**_____ **Date:**_____

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