



**PHYSICIAN'S RELEASE TO RETURN TO WORK FORM**

Employee's Name:	Date:
Physician's Name:	Telephone No.:

**To be completed by Physician**

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of \_\_\_\_\_(Date) with **NO RESTRICTIONS**.

(B) The above named employee has been released by the above named physician to Return to Work on \_\_\_\_\_(Date) **WITH THE FOLLOWING RESTRICTIONS** through \_\_\_\_\_(Date).

<b>Check applicable boxes and provide limitations/restrictions.</b>	
<input type="checkbox"/> <b>Lifting (Max weight in lbs)</b> _____ lbs.	<input type="checkbox"/> <b>Walking</b> _____ hours per day
<input type="checkbox"/> <b>Repetitive Lifting</b> _____ lbs.	<input type="checkbox"/> <b>Standing</b> _____ hours per day
<input type="checkbox"/> <b>Carrying</b> _____ lbs	<input type="checkbox"/> <b>Sitting</b> _____ hours per day
<input type="checkbox"/> <b>Pushing/pulling</b> _____ lbs.	<input type="checkbox"/> <b>Squatting</b> _____ hours per day
<input type="checkbox"/> <b>Reaching over head</b>	<input type="checkbox"/> <b>Kneeling</b> _____ hours per day
<input type="checkbox"/> <b>Reaching away from body</b>	<input type="checkbox"/> <b>Crawling</b> _____ hours per day
	<input type="checkbox"/> <b>Climbing</b> _____ hours per day
<input type="checkbox"/> <b>Repetitive Motion Restrictions:</b>	
<input type="checkbox"/> <b>Other Restrictions (include any appliances necessary for the employee to function at work):</b>	
<input type="checkbox"/> <b>Medication (include any medication that the employee may be on that would interfere with job performance):</b>	

These limitations/restrictions are:

- Temporary limitations/restrictions                       Permanent limitations/restrictions

My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physician's Signature	Date:
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