



PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Human Resources

P.O. Box 260005 Conway, SC 29528-6005

Please return form to Natasha Montgomery in Human Resources

Phone: 843-488-6559 Fax: 843-488-7754 Email: nmontgomery@horrycountyschools.net

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).

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

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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