PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	**Date:**
Physician's Name:	**Telephone #:**

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.

☐ Lifting (max weight in lbs) _____lbs. ☐ Repetitive lifting _____lbs. ☐ Carrying _____lbs. ☐ Pushing/pulling _____lbs. ☐ Pinching/Gripping _____lbs. ☐ Reaching over head ☐ Reaching away from body	☐ Walking _____ hours per day ☐ Standing _____ hours per day ☐ Sitting _____ hours per day ☐ Crawling _____ hours per day ☐ Kneeling _____ hours per day ☐ Squatting _____ hours per day ☐ Climbing _____ hours per day
☐ Other Restrictions:	
These limitations/restrictions are:	☐ Temporary limitations/restrictions ☐ Permanent limitations/restrictions

IF THE ABOVE RESTRICTION CONSTITUE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK. 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 Name (Please Print):	
Physician's Signature:	Date:

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:	Date: