Return to Work Status Form

To:______________________________ Date:______________________________

______________________________ Patient: ______________________________

> This document, when examination result(s) are completed, shall contain CONFIDENTIAL MEDICAL INFORMATION that must be maintained in a confidential locked medical file, separate from the individual's personnel file. Medical surveillance information should be kept separate from personnel and other medical information.

Work Status:
- □ Temporarily unable to work
- □ Return/continue to work with no restrictions as of ______________
- □ Return/continue to work with restrictions noted below:

Lift and/or carry:
- □ Max. 10# occasional, 5# frequent (Sedentary work)
- □ Max. 20# occasional, 10# frequent (Light work)
- □ Max 50# occasional, 25# frequent (Medium work)
- □ Max 100# occasional, 50# frequent (Heavy work)
- □ Also RUE lift/carry limited to ______# Occasionally
- □ Also LUE lift/carry limited to ______# Occasionally
- □ Other______________________________
- □ Comments: ______________________________

Push/Pull:
- □ Max________# occasional, ________# frequent
- □ Also RUE push/pull limited to ________# occasionally
- □ Also LUE push/pull limited to ________# occasionally
- □ Other______________________________
- □ Comments: ______________________________

Stand/Walk:
- □ No Limit □ Even ground only
- □ Minimal as is necessary for daily activities
- □ Limit __________hrs/day

Sit:
- □ No limit □ Limit _______ hrs/day

Drive:
- □ No Limit □ Automatic Only
- □ Smooth, paved surfaces only
- □ Limit _________ hrs/day

May use upper extremities: (within weight restrictions)
- □ No Limit □ Limit repetitive gripping
- □ No work above: waist chest shoulder

Operate heavy machinery:
- □ No Limit □ Avoid vibration
- □ Should not do □ Limit ______hrs/day

Patient is able to:

Bend	□ Frequently	□ Occasionally	□ None
Squat	□ Frequently	□ Occasionally	□ None
Climb	□ Frequently	□ Occasionally	□ None
Kneel/ Crawl	□ Frequently	□ Occasionally	□ None

Weekend Work Restrictions: □ yes □ no Comments: ______________________________

Other instructions and/or limitations: ______________________________

____

Physician's Signature:______________________________ DATE ______________________

PRINT Physicians Name______________________________ Phone______________________