# 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. | † Walking __________ hours per day |
| † Repetitive Lifting __________lbs. | † Standing __________ hours per day |
| † Carrying ____________lbs. | † Sitting __________ hours per day |
| † Pushing/pulling __________lbs. | † Crawling __________ hours per day |
| † Pinching/Gripping __________lbs. | † Kneeling __________ hours per day |
| † Reaching over head | † Squatting __________ hours per day |
| † Reaching away from body | † Climbing __________ hours per day |
| † Repetitive Motion Restrictions: | |
| † Other Restrictions: | |
| These limitations/restrictions are: | ⑥ Temporary limitations/restrictions<br>⑥ Permanent limitations/restrictions |

| Physician's Name (Printed) | | | |
|---|---|---|---|
| Physician's Signature: | | Date: | |