**Return to Work Employee Status Form**

**Employee Instructions:** Return this form to Human Resources immediately after each visit to your health care provider.

|  |  |  |  |
| --- | --- | --- | --- |
| **To:** |  | **Re:** |  |
|  | Examining Health Care Provider |  | Name of Insured Employee |
| **From:** |  |  |  |
|  | Name of Company |  | Social Security Number |

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at this company. The information you provide on this form is vital to us regarding the following:

1. The employee’s working without risk of further injury;
2. Provision of a temporary duty assignment if necessary that meets the employee’s needs and   
   the needs of the company; and
3. Provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions regarding the information requested on this form, please contact me.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name and Title |  | Phone Number |

-------------------------------------**To Be Completed by Physician**-----------------------------------

*Please see the following page for physical requirements of the employee’s duties.*

The employee’s medical condition will allow the employee:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Full Duty** (without restrictions): | | | | | |  | | | | |
|  |  | | | | | | Beginning Date | | | | |
|  | **Temporary Assignment** (modified or alternate duty): | | | | | |  | |  | | |
|  | | | | | | | Beginning Date | | | | |
|  | Estimated length of temporary Assignment: | | | | | |  | | | | |
|  |  | Full-time |  | | Part-time \_\_\_\_\_ hours per day | | | | | | |
|  | *Please indicate all restrictions to duty on the following page.* | | | | | | | | | | |
|  | **Off Work** until re-evaluated, beginning date: | | | | |  | | | | | |
|  | Date of next office visit: | | | | |  | | | | | |
|  | | |  |  | | | |  | |  |

Physician’s Name

Physician Signature Date

**Employee Restrictions to Return to Work**

*The physical requirements below marked with an “****X****” are those required of the employee in performance of his/her duties. Please mark the indicated column with a response of “Yes” if the employee can accomplish that specific task.*

*\*****Duty and Essential****—Supervisor/Manager indicates applicable duties with an “****X****.”*

*\*****Yes or No****—Marked by Health Care Provider for each duty indicated by Supervisor/Manager.*

| ***Duty*** | ***Essential*** | ***Requirements*** | ***Yes*** | ***No*** |  | ***Duty*** | ***Essential*** | ***Requirements*** | ***Yes*** | ***No*** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | *Lifting 51 lbs. and up* |  |  |  |  |  | *Simple grasping* |  |  |
|  |  | *Lifting 26-50 lbs.* |  |  |  |  |  | *Power grasping* |  |  |
|  |  | *Lifting up to 25 lbs.* |  |  |  |  |  | *Simultaneous grasping* |  |  |
|  |  | *Carrying 51 lbs. & up* |  |  |  |  |  | *Squeezing* |  |  |
|  |  | *Carrying 26-50 lbs.* |  |  |  |  |  | *Driving motor vehicle* |  |  |
|  |  | *Carrying up to 25 lbs.* |  |  |  |  |  | *Operating mechanical equipment* |  |  |
|  |  | *Bending* |  |  |  |  |  | *Type:* | | |
|  |  | *Stooping* |  |  |  |  |  | *Operating office equipment* |  |  |
|  |  | *Kneeling* |  |  |  |  |  | *Type:* | | |
|  |  | *Crawling* |  |  |  |  |  | *Speaking* |  |  |
|  |  | *Standing* |  |  |  |  |  | *Hearing* |  |  |
|  |  | *Squatting* |  |  |  |  |  | *Ability to type* |  |  |
|  |  | *Climbing stairs* |  |  |  |  |  | *Ability to see* |  |  |
|  |  | *Climbing ladders* |  |  |  |  |  | *Depth perception needed* |  |  |
|  |  | *Twisting* |  |  |  |  |  | *Ability to write* |  |  |
|  |  | *Pulling* |  |  |  |  |  | *Ability to read* |  |  |
|  |  | *Pulling hand over hand* |  |  |  |  |  | *Vibration* |  |  |
|  |  | *Pushing* |  |  |  |  |  | *Noise* |  |  |
|  |  | *Sitting* |  |  |  |  |  | *Extreme heat* |  |  |
|  |  | *Walking* |  |  |  |  |  | *Extreme cold* |  |  |
|  |  | *Work on elevated surface* |  |  |  |  |  | *Wet and/or humid* |  |  |
|  |  | *Work on uneven ground* |  |  |  |  |  | *Chemicals* |  |  |
|  |  | *Work at low position* |  |  |  |  |  |  |  |  |
|  |  | *Reach above shoulders* |  |  |  |  |  |  |  |  |
|  |  | *Reach below shoulders* |  |  |  |  |  |  |  |  |
|  |  | *Must be able to intervene with individuals in combative or aggressive situations in an emergency.* | | | | | | |  |  |
|  |  | *Must be able to perform Cardiovascular Pulmonary Resuscitation (CPR) in an emergency.* | | | | | | |  |  |
|  |  | *Other specified by Supervisor/Manager* | | | | | | |  |  |

*Please specify any and all other restrictions to duty:*