LEHIGH UNIVERSITY

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

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

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, a period of up to four weeks):

Check applicable boxes and provide limitations/restrictions.	
□ Lifting (Max weight) _____ lbs.	□ Walking _____ hours per day
□ Repetitive Lifting _____ lbs.	□ Standing _____ hours per day
□ Carrying _____lbs.	□ Sitting _____hours per day
□ Pushing/pulling _____lbs.	□ Stooping_____ hours per day
□ Pinching/Gripping _____lbs.	□ Kneeling/ Crawling_____ hours per day
□ Reaching over head	□ Squatting/ Crouching _____ hours per day
□ Reaching away from body	□ Climbing/ Balancing _____ hours per day
□ Repetitive Motion Restrictions: _____ □ Duration of Activity per day_____/ per week_____	
□ Other Restrictions:	
These limitations/restrictions are:	□ Temporary limitations/restrictions
	□ Permanent limitations/restrictions
Prognosis for return to full duty(s):	□ Undetermined
	□ Date:

IF THE ABOVE RESTRICTIONS CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL NOT BE RETURNING TO WORK. My signature indicates that I have read and understand the employee's position description (attached) and the listed tasks within the position description and that my findings are based on my medical assessment of this employee's physical and cognitive capabilities as compared to the essential functions of the job.

Physician's Name (Please Print): _____
Physician's Signature: _____Date:_____

To be completed by Employee: I UNDERSTAND AND AGREE THAT: I must make an appointment with Human Resources before returning to work. I will follow through with all of the restrictions listed above, and agree to notify my supervisor and Human Resources of any departure from these restrictions. This form must be updated every four weeks.

Employee's Signature: _____Date:_____