PHYSICIAN’S RELEASE TO RETURN TO WORK FORM

<table>
<thead>
<tr>
<th>Employee’s Name:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Physician’s Name:</td>
<td>Telephone #:</td>
</tr>
<tr>
<td>Physician’s Specialty:</td>
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**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):

- [ ] 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:

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<tr>
<th>These limitations/restrictions are:</th>
<th>[ ] Temporary limitations/restrictions</th>
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<tbody>
<tr>
<td></td>
<td>[ ] Permanent limitations/restrictions</td>
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<tr>
<th>Prognosis for return to full duty(s):</th>
<th>[ ] Undetermined</th>
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<tbody>
<tr>
<td></td>
<td>[ ] Date:</td>
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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:_________