



HEALTHCARE PROVIDER'S RELEASE TO RETURN TO WORK FORM

Employee's Name: Date:
Healthcare Provider's Name: Telephone #:
Healthcare Provider's Specialty:

To Be Completed by Healthcare Provider:

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):

Employee Work Limitations or Restrictions

Please address **ONLY** physical and/or mental/behavioral limitations that:

- the employee has as a result of an impairment identified below **AND** • relate to the performance of the duties of his or her employment position

Examples of physical limitations: Lifting, bending, reaching, kneeling, sitting, standing, walking, pushing, pulling, use of hands or arms, exposure to heat or cold, etc. *Include specific limitations* such as the expected duration of each limitation or restriction, pound limits for lifting restrictions, or any other relevant information to help the employer understand your patient's limitations and what your patient needs to perform his/her job.

Examples of cognitive/mental/behavioral limitations: Concentration, memory, focus, oral or written communication, expressing thoughts, organization, multitasking, synthesizing information, maintaining attendance, exercising judgment, interacting with others, time management, flexibility with change, etc. *Include specific limitations* such as the expected duration of each limitation or restriction, modifications to work place setting, and any other relevant information to help the employer understand your patient's limitations and what your patient

needs to perform his/her job.

Impairment or Diagnosis causing job-related limitations or restrictions	Specific job-related limitations or restrictions

Use additional page if needed.

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:** _____