Emergency Management, Buildings & Safety

In:_____
Appointment Time:_____
Out:_____

RETURN TO WORK / PHYSICAL CAPABILITIES REPORT

Employee Name:_____ Date of Birth_____/_____/_____

Position/Job Title_____ Company Name_____

Date of Injury: _____/_____/_____ Company Address_____ Phone #_____

TO BE COMPLETED BY ATTENDING MEDICAL PROVIDER

If Diagnosis: 1. _____
If (work related)
2. _____

Medically Work Related: ❑ Yes ❑ No ❑ Undetermined **Condition:** ❑ Improved ❑ Unchanged ❑ Worsened ❑ Not Applicable

WORK DEFINITIONS

Work Level (Lift/ Carry)		Per Work Shift	
Sedentary	0-10 lbs.	Never (Nvr)	0%
Light	10 lbs. freq. - 20 lbs. max	Seldom	1-10%
Light-Medium	20 lbs. freq. - 35 lbs. max	Occasionally	11-33%
Medium	20 lbs. freq. - 50 lbs. max	Frequently	34-66%
Heavy	50 lbs. freq. - 100 lbs. max	Continually	67-100%

WORK/OFF WORK - RESTRICTIONS AND CAPABILITIES

I saw this patient on_____/_____/_____

- ❑ 1. Prescription medication prescribed. ❑ Medications prescribed may affect work performance.
- ❑ 2. Stitches or Butterflies used for wound closure.
- ❑ 3. Employee is totally disabled because_____
- ❑ 4. Employee should be able to return to work on _____/_____/_____ subject to the following restrictions untill _____/_____/_____ ❑ Permanent
- ❑ 5. Will be re-evaluated on _____/_____/_____ by_____ at_____
- ❑ 6. Employee should be able to return to previous work without restrictions on _____/_____/_____
- ❑ 7. Employee Discharged.

(UNCHECKED ITEMS ARE NOT RESTRICTED)

Work Level ☞ ❑ Sed ❑ Light ❑ Light/Med ❑ Medium ❑ Heavy

Hours/day _____

Days/week _____

Days overtime/wk _____

May drive_____ hrs at a time_____hrs/day

May sit _____ hrs at a time_____hrs/day

May walk/stand_____hrs at a time_____hrs/day

Should change positions every_____hour/s

May work between_____and_____elevation

Not work more than_____inches from body

SPECIFY - RIGHT, LEFT OR BILATERAL (CIRCLE R-L-BL)

Grasp:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Pinch:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Twist (wrist):	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Push/Pull:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Fine finger manipulation:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Wrist flexion/extension:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Feet for repetitive movements:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	R - L - BL
Exposure to unprotected heights:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	
Exposure to moving machinery:	❑ Nvr.	❑ Seldom	❑ Occas.	❑ Freq.	

MAY BEND: ❑ ❑ ❑ ❑

Bend:	❑ Never	❑ Seldom	❑ Ocass.	❑ Freq.
Squat:	❑ Never	❑ Seldom	❑ Ocass.	❑ Freq.
Climb:	❑ Never	❑ Seldom	❑ Ocass.	❑ Freq.
Crawl:	❑ Never	❑ Seldom	❑ Ocass.	❑ Freq.
Twist:	❑ Never	❑ Seldom	❑ Ocass.	❑ Freq.

OTHER COMMENTS / RECOMMENDATIONS:

Medical Provider's written signature: (No Stamps) Date

Medical Provider's Printed or Stamped Name / Address / City / State: Phone:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending Medical Provider and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or employer's representative.

Patient's Signature: _____Date _____/_____/_____

SCH994569 **DISTRIBUTION:** **WHITE COPY - Medical Records** **YELLOW COPY - Employer** **PINK COPY - Employee**