RETURN TO WORK DOCTORS NOTE FORM

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

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):

Check applicable boxes and provide limitations/restrictions.	
☐ Lifting (Max weight in lbs) _____lbs.	☐ Walking _____ hours per day
☐ Repetitive Lifting _____lbs.	☐ Standing _____ hours per day
☐ Carrying _____lbs.	☐ Sitting _____ hours per day
☐ Pushing/pulling _____lbs.	☐ Crawling _____ hours per day
☐ Pinching/Gripping _____lbs.	☐ Kneeling _____ hours per day
☐ Reaching over head	☐ Squatting _____ hours per day
☐ Reaching away from body	☐ Climbing _____ hours per day
☐ Repetitive Motion Restrictions:	
☐ Other Restrictions:	
These limitations/restrictions are:	☐ Temporary limitations/restrictions ☐ Permanent limitations/restrictions

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

Physician's Name (Please Print):			
Physician's Signature:		Date:	

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:		Date:	