# PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

| | |
|---|---|
| Employee's Name: | Date: |
| Physician's Name: | Phone #: |

**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 overhead | ☐ Squatting _____ hours per day |
| ☐ Reaching away from body | ☐ Climbing _____ hours per day |
| ☐ Repetitive Motion Restrictions: | |
| ☐ Other Restrictions: | |

| | | | |
|---|---|---|---|
| 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: | |