



RETURN TO WORK REPORT

TO BE COMPLETED BY INJURED/ILL WORKER

Date of Visit _____ Date of Injury/Illness _____ Social Security # _____
 Employee Name _____ Birth Date _____
 Address _____ Phone () _____
 City _____ State _____ Zip _____

TO BE COMPLETED BY PHYSICIAN/HOSPITAL STAFF

Initial Treatment Follow-Up visit

WORK STATUS: ↓

Employee may return to work on _____ with modified duties *as listed below*, effective until _____

- No lifting over _____ lbs.
- No work above ground or surface level
- No pushing or pulling over _____ lbs.
- No work around high speed or moving machinery
- No kneeling or squatting
- No standing more than _____ at a time
- Other: _____

- No walking more than _____ at a time
- No reaching above shoulder level
- No repetitive bending or twisting
- No sitting more than _____ at a time
- No operating mobile equipment
- No climbing of stairs or ladders
- No driving of motor vehicle

Employee may return to full work duties on _____ with no restrictions or limitations.

RECHECK: Employee will be rechecked by physician on _____, 20____ @ Time: _____ a.m./p.m.

RECOMMENDATIONS: _____

PHYSICIAN'S SIGNATURE _____ Date _____

PHYSICIAN'S NAME (printed) _____

