FRONTIER BUILDING

Return to Work Release Form

Instructions:

Immediate Supervisor: Give this form with the employee's up-to-date job description attached to the employee.

Employee: Have your health care provider review your attached job description and ask him/her to complete this form. Return the completed form to your supervisor before you return to work.

Health Care Provider: Please review the attached job description for this employee, complete this form, and return it to the patient.

Employee name: _____

Department: _____

Date the condition began: _____

Please check one of the following:

__ The employee is able to work a full, regular schedule with no restrictions, beginning _____(date)

__ The employee is unable to return to work until _____(date)

__ The employee is able to return to work on a reduced schedule for ___ hours a day from _____(date) through_____ (date)

__ The employee is able to return to work with restrictions from_____ (date) through_____ (date).

Please indicate restrictions, if any, below for:

Standing (number of hours): _____

Walking (number of hours): _____

Sitting (number of hours): _____

Lifting (number of pounds): _____

Carrying (number of pounds): _____

Use of hands (repetitive motions, pushing, pulling): _____

Any other restrictions:

_____

_____

Signature of Health Care Provider: _____

Printed Name of Health Care Provider: _____

Date: _____