

# Department of Administrative Services – Release to Return to Work Status

*Return form to: DAS – Human Resources office at [as.human.resources@nebraska.gov](mailto:as.human.resources@nebraska.gov) or fax to 402-742-8361*

Name of employee _____	Medical Diagnosis _____
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**Medical Provider: Please complete the following information.**

1. Has our employee reached maximum medical improvement, MMI, to report to work?  Yes  No  
 Date Achieved MMI \_\_\_\_\_ If NO, next scheduled appointment date for evaluation \_\_\_\_\_

2. Employee is released to:  
 full duty without limitations Date \_\_\_\_\_ (Do not complete questions 3 through 11. Sign below.)  
 modified duty from \_\_\_\_\_ date to \_\_\_\_\_ date (specify limitations below.)  
 modified hours (specify here) \_\_\_\_\_ Dates: from \_\_\_\_\_ date to \_\_\_\_\_ date

	Number of Hours									
	No limit	1	2	3	4	5	6	7	8	
3. In an eight-hour workday, employee can stand/walk a total	<input type="checkbox"/>									
4. At one time, employee can stand/walk	<input type="checkbox"/>									
5. In an eight-hour workday, employee can sit a total of	<input type="checkbox"/>									
6. At one time, employee can sit a total of	<input type="checkbox"/>									

7. The employee is able to work in the following range for lifting, carrying, pushing/pulling: Occasionally 6-33% of the workday or frequently 34-66% of the workday.

Pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100
Occasionally	<input type="checkbox"/>																				
Frequently	<input type="checkbox"/>																				

8. Employee can use hands for repetitive

	<b>Right</b>		<b>Left</b>	
a. Fine manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Pushing and pulling	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Simple grasping	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Keyboarding	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dominant hand**  
 Right  Left

9. Employee can use feet for repetitive raising and pushing (as in operating foot controls)  Yes  No

10. Employee is able to

	Continuously 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Stoop/bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Other functional limitations or modifications necessary in our employee's employment:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Additional comments may be written on back of form.**

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize my attending Physician and/or Hospital to release any information or copies thereof acquired in the course of my examination or treatment to my employer or his/her representative.

_____ Employee signature	_____ Employee printed name	_____ Date
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Physician Clinic (Address & Phone): _____		
_____ Physician signature	_____ Physician printed name	_____ Date