

# RELEASE TO RETURN TO WORK

Name of worker	Claim number
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**Please complete the following information and return with the injured employee.**

1. Is the worker medically stationary?  Yes      Date \_\_\_\_\_  
 No      Next scheduled appointment date \_\_\_\_\_

2. Worker is released to:

full duty without limitations      Date \_\_\_\_\_ (Do not complete lines 3 through 11. Sign below.)

modified duty from (date) \_\_\_\_\_ through (date) \_\_\_\_\_ (specify limitations below.)

modified hours — specify \_\_\_\_\_ from (date) \_\_\_\_\_ through (date) \_\_\_\_\_

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

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

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. Worker can use hands for repetitive:

	<b>Right</b>		<b>Left</b>		<b>Dominant hand</b>
a. Fine manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Right <input type="checkbox"/> Left
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		

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

10. Worker is able to:

	Continuous 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 worker's employment:

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

Signature of physician	Physician's typed name	Date
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