Return-to-Work Program Status Form

Employee Instructions: Return this form to your supervisor/manager immediately after each visit to your health care provider.

To: ______________________ Examining Health Care Provider

Re: ______________________ Name of Insured Employee

From: ______________________ Name of Organization

______________________ Social Security Number

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at this organization. The information you provide on this form is vital to us regarding the following:

A. The employee's working without risk of further injury;

B. Provision of a temporary duty assignment if necessary that meets the employee's needs and the needs of the organization; and

C. Provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions regarding the information requested on this form, please contact me.

______________________ Name and Title

______________________ Phone Number

To Be Completed By Physician

(See the next page for physical requirements of the employee's duties.)

The injured employee's medical condition resulting from this worker's compensation injury will allow the employee

☐ **Full Duty** (without restrictions): ______________________ Beginning Date

☐ **Temporary Assignment** (modified or alternate duty): ______________________ Beginning Date

Estimated length of temporary Assignment:

☐ Full-time ☐ Part-time _____ hours per day

(Please indicate restrictions to duty on the next page.)

☐ **Off Work** until re-evaluated, beginning date: ______________________

Date of next office visit: ______________________

______________________ Physician's Name (Printed)

______________________ Physician's Signature

______________________ Date

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Medical Provider Instructions: The physical requirements below marked with an **X** are those required of the employee in performance of his/her duties. Please mark the indicated column with a response of Yes"if the employee can accomplish that specific task.

*__Duty and Essential__—Supervisor/Manager indicates applicable duties with an **X**.

*__Yes or No__—Marked by Health Care Provider for each duty indicated by Supervisor/Manager.

Duty	Essential	Requirements	Yes	No		Duty	Essential	Requirements	Yes	No
		Lifting 51 lbs. and up						Simple grasping		
		Lifting 26-50 lbs.						Power grasping		
		Lifting up to 25 lbs.						Simultaneous grasping		
		Carrying 51 lbs. & up						Squeezing		
		Carrying 26-50 lbs.						Driving motor vehicle		
		Carrying up to 25 lbs.						Operating mechanical equipment		
		Bending						Type:		
		Stooping						Operating office equipment		
		Kneeling						Type:		
		Crawling						Speaking		
		Standing						Hearing		
		Squatting						Ability to type		
		Climbing stairs						Ability to see		
		Climbing ladders						Depth perception needed		
		Twisting						Ability to write		
		Pulling						Ability to read		
		Pulling hand over hand						Vibration		
		Pushing						Noise		
		Sitting						Extreme heat		
		Walking						Extreme cold		
		Work on elevated surface						Wet and/or humid		
		Work on uneven ground						Chemicals		
		Work at low position								
		Reach above shoulders								
		Reach below shoulders								
		Must be able to intervene with individuals in combative or aggressive situations in an emergency.								
		Must be able to perform Cardiovascular Pulmonary Resuscitation (CPR) in an emergency.								
		Other specified by Supervisor/Manager								

Please specify any additional restrictions to duty:

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