OFFICE OF HUMAN RESOURCES

PHYSICIAN REPORT
RETURN TO WORK EVALUATION

THIS FORM MUST BE RETURNED TO THE OFFICE OF HUMAN RESOURCES PRIOR TO RETURNING TO WORK

Employee's Name: ______________________________ Date: ______________________________

Job Title: ______________________________________ Department: ________________________

Attending Physicians Report

(please check appropriate boxes below)

Date of last treatment: ________________ Date of next follow-up appointment: ______________

Diagnosis: ____

- ❑ Patient may resume regular work duties as of this date:_____________________________.
- ❑ Patent is unable to resume regular work duties:
  - ❑ Temporarily. ❑ Permanently.
  - ❑ Patient is able to work on modified duty as of this date: ____________________
    - Patient is able to:
      - Bend: ❑ Yes ❑ No
      - Squat: ❑ Yes ❑ No
      - Climb: ❑ Yes ❑ No
      - Lift: ❑ Yes ❑ No
    - Patient can lift up to: ❑ 20 lbs. ❑ 50 lbs. ❑ over 50 lbs.
    - If hand/arm injury, patient can use hands for repetitive movements:
      - Simple grasping: ❑ Yes ❑ No
      - Pulling and pushing: ❑ Yes ❑ No
      - Repetitive wrist motion: ❑ Yes ❑ No
    - If foot injury, patient can use feet for repetitive movements:

      ❑ Yes❑ No
    - Further details of modified duty:
    - ____

Physician's Name: ________________________________ Telephone #: ____________________

Physician's Signature: ________________________________ Date: ____________________

2/6/14 *revised*