Name: Date of Visit: Employer: Job Title/Description:

(If workers' compensation: Date of Injury: Claim #: Diagnosis:)

Return to work recommendations:

☐ **Released** to usual work without restrictions as of (date): _____.

☐ **Released** to usual work as tolerated as of (date) _____; patient may require temporary adjustments for pain.

☐ **May perform modified duty**, if available, from (date) _____ to (date) _____. (*See below*.)

☐ **May work limited hours**: _____hours/day from (date) _____ to (date) _____.

☐ **Not released to any work** from (date): _____ Anticipated date to return to work: _____

		For each alteration, please check reason.			Recommended frequency of altered functions		
Abilities Affected by Condition	NO LIMIT	PROHIBITED: POSES A RISK	REDUCED CAPACITY	AS TOLERATED	Never	Occasional	Frequent
Sit	☐	☐	☐	☐			
Stand/Walk	☐	☐	☐	☐			
Climb (ladder/stairs)	☐	☐	☐	☐			
Twist	☐	☐	☐	☐			
Bend/Stoop	☐	☐	☐	☐			
Squat/Kneel	☐	☐	☐	☐			
Crawl	☐	☐	☐	☐			
Reach: left / right / both	☐	☐	☐	☐			
Work above shoulder L / R / both	☐	☐	☐	☐			
Keyboard	☐	☐	☐	☐			
Wrist Motion L/ R / both	☐	☐	☐	☐			
Grasp (forceful) L / R / both	☐	☐	☐	☐			
Fine Manipulation L / R / both	☐	☐	☐	☐			
Operate foot controls L/ R / both	☐	☐	☐	☐			
					Specify weight for each frequency below		
Weight Handling	NO LIMIT	PROHIBITED: POSES A RISK	REDUCED CAPACITY	AS TOLERATED	Never	Occasional	Frequent
Lift - L/ R / both	☐	☐	☐	☐	lbs	lbs	lbs
Carry - L/ R / both	☐	☐	☐	☐	lbs	lbs	lbs
Push / Pull	☐	☐	☐	☐	lbs	lbs	lbs

Other recommendations:

Treatment Plan:

☐ No further care required. ☐ Follow-up appointment here on (date) _____

☐ Referred for other services elsewhere: _____

These recommendations are an estimate of this worker's ability to perform tasks while recovering from this condition. Staying active at work is important for recovery. Please call my office to discuss if needed.

_____ _____ _____

Physician Name Signature Date