

Human Resource Administration
1515 West Lincoln Hwy.
DeKalb, IL 60115
815/753-1119 Fax: 815/753-1001

**EMPLOYEE'S
RETURN TO WORK
FORM**

Must be completed legibly by physician

Patient's Name: _____ Date of Onset: _____

Date(s) of Treatment _____

History: _____

Name(s) of other physician(s) or medical providers who have served on case: _____

Diagnosis: _____

Treatment (Proposed or completed): _____

Medication(s): _____

Prognosis: _____

First day off work: _____ **Estimated** return to work date: _____

Actual Return to Work **without** restrictions: _____

Return to work **with** reduced schedule: _____

Number of hours per day: _____ Number of days per week: _____

Beginning: _____ Ending: _____

Return to work with the following restrictions: Beginning: _____ Ending: _____

<input type="checkbox"/> Lifting (weight)	0-10 lbs	11-25 lbs.	26-40 lbs.	41-50 lbs	over 50 lbs.
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Lifting

From floor	25%	50%	75%	100%
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From waist level	25%	50%	75%	100%
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Over the shoulder/head	25%	50%	75%	100%
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<input type="checkbox"/> Pushing/pulling (weight)	0-10 lbs	11-25 lbs.	26-40 lbs.	41-50 lbs	over 50 lbs.
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<input type="checkbox"/> Pushing/pulling frequency	25%	50%	75%	100%
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<input type="checkbox"/> Standing	25%	50%	75%	100%
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<input type="checkbox"/> Sitting	25%	50%	75%	100%
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<input type="checkbox"/> Walking	25%	50%	75%	100%
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<input type="checkbox"/> Climbing	25%	50%	75%	100%
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<input type="checkbox"/> Bending	25%	50%	75%	100%
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<input type="checkbox"/> Reaching 18" from body	25%	50%	75%	100%
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From shoulder level	25%	50%	75%	100%
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Over the head	25%	50%	75%	100%
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<input type="checkbox"/> Kneeling/Squatting	25%	50%	75%	100%
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No operating moving machinery

No Driving

Additional instruction: _____

Date of next office visit: _____

Physician's Name: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

Physician's Signature: _____ Date: _____