

Return form to:

RETURN-TO-WORK STATUS

Worker's name: _____ Claim number (if known): _____

Next scheduled appointment date: _____

Is the worker expected to materially improve from medical treatment or the passage of time? Yes No

WORK STATUS *(Select one option)*

OPTION 1 – Released to Regular Work Status from (date): _____
Released to the *hours routinely worked and tasks routinely performed in the job held at the time of injury.*

OPTION 2 – Not Released to Work Status from (date): _____ to: _____
The worker is *not capable of performing any work activities.*

OPTION 3 – Released to Modified Work Status from (date): _____ to: _____
Released to work, *subject to the following work restrictions (note only those that are applicable):*

Total work hours: _____ hours/day

Lift/carry/push/pull restrictions

	<i>One-time</i>	<i>≤1/3 of workday</i>	<i>1/3-2/3 of workday</i>	<i>≥2/3 of workday</i>	<i>Duration</i>	
Lift:	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
Carry:	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
Push:	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time
Pull:	_____ pounds	_____ pounds	_____ pounds	_____ pounds	_____ hrs./day	_____ hrs./one time

Activity restrictions

Stand:	_____ hrs./day	_____ hrs./one time	Twist:	_____ hrs./day	_____ hrs./one time	Crawl:	_____ hrs./day	_____ hrs./one time
Walk:	_____ hrs./day	_____ hrs./one time	Climb:	_____ hrs./day	_____ hrs./one time	Crouch:	_____ hrs./day	_____ hrs./one time
Sit:	_____ hrs./day	_____ hrs./one time	Bend:	_____ hrs./day	_____ hrs./one time	Balance:	_____ hrs./day	_____ hrs./one time
Drive:	_____ hrs./day	_____ hrs./one time	Above-shoulder-reach:	_____ hrs./day	_____ hrs./one time	Below-shoulder-reach:	_____ hrs./day	_____ hrs./one time
Kneel:	_____ hrs./day	_____ hrs./one time						

Hand use restrictions

Fine actions:	_____ hrs./day L hand	_____ hrs./day R hand
Keyboarding:	_____ hrs./day L hand	_____ hrs./day R hand
Grasp:	_____ hrs./day L hand	_____ hrs./day R hand

Foot use restrictions

Raise:	_____ hrs./day L foot	_____ hrs./day R foot
Push:	_____ hrs./day L foot	_____ hrs./day R foot

Notes / other restrictions: _____

Medical provider's signature: _____

Date: _____

Print medical provider's name: _____

Phone no.: _____