 **Physician Release and/or Return to Work Statement**

**Employee Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1. In an 8-hour work day, patient can (circle full capacity for each):**

**Sit** 1 2 3 4 5 6 7 8 Hours/Day

**Stand**  1 2 3 4 5 6 7 8 Hours/Day

**Walk** 1 2 3 4 5 6 7 8 Hours/Day

Any Restrictions [ ] Permanent [ ] Temporary / Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Patient can lift / carry:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | | **Sometimes** | | **Most of the Time** | | **No Restrictions** |
| **Lift** | **Carry** | **Lift** | **Carry** | **Lift** | **Carry** |
| **00-10 lbs.** |  |  |  |  |  |  |  |
| **11-25 lbs.** |  |  |  |  |  |  |  |
| **26-50 lbs. (w/ assistance)** |  |  |  |  |  |  |  |
| **51-100 lbs. (w/ assistance)** |  |  |  |  |  |  |  |
| **>100 lbs. (w/ assistance)** |  |  |  |  |  |  |  |

Any Restrictions [ ] Permanent [ ] Temporary / Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Patient can use hand for repetitive motions (circle as appropriate):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Right Hand** | **Left Hand** | **Restrictions** | **Permanent** | **Temporary/Duration** |
| **Simple Grasping** |  |  |  |  |  |
| **Fine Manipulation** |  |  |  |  |  |
| **Pushing / Pulling** |  |  |  |  |  |

**4. Patient can use feet for repetitive (i.e. foot controls):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Restrictions** | **Permanent** | **Temporary/Duration** |
| **Right Foot** |  |  |  |  |  |
| **Left Foot** |  |  |  |  |  |

**5. Patient is able to:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Never** | **Sometimes** | **Most of the Time** | **No Restrictions** |
| **Bend** |  |  |  |  |
| **Climb** |  |  |  |  |
| **Crawl** |  |  |  |  |
| **Squat** |  |  |  |  |
| **Reach** |  |  |  |  |
| **Twist** |  |  |  |  |
| **Drive a Car** |  |  |  |  |
| **Drive a Truck** |  |  |  |  |
| **Drive a Van** |  |  |  |  |
| **Drive/Operate Heavy Equipment** |  |  |  |  |

Any Restrictions [ ] Permanent [ ] Temporary / Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Is patient involved with treatment and/or medication that might affect their ability to work?**

[ ] No Restrictions

[ ] Yes – Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Will patient require any assistive braces or devices:**

[ ] No Restrictions

[ ] Yes – Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Is patient’s condition:** [ ] Permanent [ ] Temporary / Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. When will patient be able to resume essential job duties with no restrictions (Job Description attached):**

[ ] Immediately [ ] Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. General Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |
| --- | --- | --- | --- |
| **Physician’s Name** |  | **Date** |  |
| **Physician’s Practice Address** |  | **Physician’s Practice Phone Number** |  |
| **Physician’s Signature** |  | | |

***To be completed in full by treating physician when employee’s is ready to return to work.***

***Submit to:***

***Eileen Quinn, HR Benefits Administrator***

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