GENESEO Return to Work Form

Name of Patient: _____ Patient Phone #:_____

Name & Title of Health Care Provider: _____

Physician Phone #:_____ Physician Fax #:_____

Dates of Treatment/Office Visits: _____

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1. Following review of the position description, I certify that in my medical opinion, this patient is unable to work from (begin date):_____ to (end date):_____.

2. ☐ May return to full, unrestricted duty on (specify date):_____.

   ☐ May return with restrictions on (specify date): _____ **(if this box is checked, complete questions 3-6)**.

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3. In an 8 hour workday, how many hours can this employee: (please check appropriate boxes)

Sit	☐1☐2☐3☐4☐5☐6☐7☐8	☐ Continuously	☐ With Rests
Stand	☐1☐2☐3☐4☐5☐6☐7☐8	☐ Continuously	☐ With Rests
Walk	☐1☐2☐3☐4☐5☐6☐7☐8	☐ Continuously	☐ With Rests

In a given day, for how many hours can this employee sit, stand, and/or walk in combination?
☐2 ☐4 ☐6 ☐8 ☐10 ☐12 ☐14 ☐16 ☐Greater than 16

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4. Other Capabilities: (please check appropriate boxes)

	Never	Occasionally	Frequently	Continuously
Lift				
0-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
Carry				
0-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing and Pulling	Fine Manipulation
Right	☐Y ☐N	☐Y ☐N	☐Y ☐N
Left	☐Y ☐N	☐Y ☐N	☐Y ☐N

Lower Extremities:

Use of feet/legs for repetitive movement as in operation of foot controls and motor vehicles:

Right Extremity	Left Extremity	Simultaneously
☐Y ☐N	☐Y ☐N	☐Y ☐N

5. Work Environment Restrictions:

   Can this employee:

   Be exposed to marked changes in temperature and humidity? ☐ Y ☐ N

   Be exposed to unprotected heights? ☐ Y ☐ N

   Be around moving machinery? ☐ Y ☐ N

6. Other Restrictions Explain:

   _____

   _____

   _____

_____

Health Care Provider Signature **Date**

Authorization to Disclose Medical Records and/or Services Provided or Received. I authorize the release of any medical information necessary to process the above request.

_____

Patient's Signature **Date**

Please return form at least 48 business hours prior to the return to work date indicated above.

Mark CONFIDENTIAL to:

Rebecca Farrington
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