

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: _____

- 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): _____.
- ☐ 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).

- 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

- 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:

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