Return-to-Work Authorization Form

Patient (Employee) Name:	Doctor Visit Date:

Return to Work Specifications

Employee may return to full-duty with no restrictions:	Return to Work Date:	
Employee is to remain off work:	From (date):	To (date):
Employee may perform modified duty *(outlined below):*	From (date):	To (date):
Employee may work limited hours per day - # of hours per day:	From (date):	To (date):
Employee will be re-evaluated on:	Date:	

Modified Duty Specifications

Activity	Never	Seldom 1 – 10% 0-1 hr	Occasional 11 – 33% 1 – 3 hrs	Frequent 34 – 66% 3 – 6 hrs	Continuous 67 – 99%	Not Restricted	Forces Weights	Occasional 0 – 32 reps	Frequent 33 – 199 reps	Continuous 200+ reps	Distance Height
Standing	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Walking	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Driving	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Lifting	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Carrying	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Pushing	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Pulling	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Squatting/Stooping	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Bending/Kneeling	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Bending - Elbows	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Bending - Waist	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Crawling	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Climbing - Stairs	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Climbing - Ladder	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Climbing - Stairs	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Reaching - Overhead	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Reaching - Below	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Hand – Open/Close	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Hand – Grasp (forceful)	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Hand - Pinch	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Hand – Fine Manipulation	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Keyboard	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Wrist – Flex/Extension	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Operate Foot Controls	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Vibratory – High Impact	☐	☐	☐	☐	☐	☐		☐	☐	☐	
Vibratory – Low Impact	☐	☐	☐	☐	☐	☐		☐	☐	☐	

Physician Authorization Signature

Physician Signature:	Print Name:	Date:
Healthcare Center's Name (print):		
Address:		
City:	State:	ZIP:
Phone:	Fax:	