RETURN TO WORK STATUS FORM

TO: **EXAMINING HEALTH CARE PROVIDER** RE: _____
Name of Employee

FROM: _____ _____
Name of State Agency Employee ID #

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at this agency. The information you provide on this form is vital to us regarding the:

A. employee's working without risk of further injury;
B. provision of a temporary duty assignment if necessary that meets the employee's needs and the needs of this agency;
C. provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions regarding the information requested on this form, please contact:

Carolina Bryan, HR Specialist **(409) 880-8375**
Name and Title Phone Number

TO BE COMPLETED BY PHYSICIAN:
(See reverse side for physical requirements of employee's duties.)

Considering this employee's job duties and health condition, this employee may perform work in the following manner:

___ **FULL DUTY** (no restrictions) beginning: _____
Date

___ **TEMPORARY ASSIGNMENT** (Modified or Alternate Duty) beginning: _____
Date

Estimated Length of Temporary Assignment: _____
☐ Full-Time ☐ Part-Time (_____ hours per day)
(Please indicate restrictions to duty on reverse side)

___ **OFF WORK** until re-evaluated, beginning on: _____
Date

Date of next office visit: _____
Date

_____ _____
Physician's Signature Date

FOR AGENCY USE:

Temporary Duty Assignment Begins: _____ Ends: _____
Temporary Duty Assignment:
_____
The specific duties of the temporary assignment must be provided in a written offer of employment.

EMPLOYEE INSTRUCTIONS:

Return this form to your supervisor immediately after each visit to your health care provider.

INSTRUCTIONS TO HEALTH CARE PROVIDER:

The physical requirements below, marked with an "X", are those required of the employee in performance of his/her duties. Please mark the indicated column with a response of "Yes" if the employee can accomplish that specific task.

*** DUTY** Sections– Supervisor indicates with an "X" those that are applicable.
**** YES/NO** Sections – Marked by Health Care Provider for each duty indicated by supervisor.

DUTY	REQUIREMENTS	YES	NO	DUTY	REQUIREMENTS	YES	NO
☐	Heavy lifting, 45 lbs. & up	____	____	☐	Heavy carrying, 45 lbs. & up	____	____
☐	Moderate lifting, 15-45 lbs.	____	____	☐	Moderate carrying, 15-45 lbs.	____	____
☐	Light lifting, up to 15 lbs.	____	____	☐	Light carrying, up to 15 lbs.	____	____
☐	Straight pulling	____	____	☐	Pulling hand over hand	____	____
☐	Repeated bending	____	____	☐	Reaching above shoulders	____	____
☐	Simple grasping	____	____	☐	Dual simultaneous grasping	____	____
☐	Walking	____	____	☐	Standing	____	____
☐	Sitting	____	____	☐	Crawling	____	____
☐	Twisting	____	____	☐	Kneeling	____	____
☐	Pushing	____	____	☐	Stooping	____	____
☐	Climbing Stairs	____	____	☐	Climbing ladders	____	____
☐	Operating mechanical equip.	____	____	☐	Operating office equipment	____	____
☐	Specify: _____	____	____	☐	Specify: _____	____	____
☐	Operating a motor vehicle	____	____	☐	Hearing	____	____
☐	Speaking	____	____	☐	Depth perception needed	____	____
☐	Ability to type	____	____	☐	Ability to see	____	____
☐	Ability to write	____	____	☐	Ability to read	____	____
☐	Must be able to intervene with individuals in combative or aggressive situations in an emergency					____	____
☐	Must be able to perform Cardiovascular Pulmonary Resuscitation (CPR) in an emergency					____	____

OTHER ACTIVITIES SPECIFIED BY SUPERVISOR:

☐	_____	____	____
☐	_____	____	____

PLEASE SPECIFY ANY ADDITIONAL RESTRICTIONS TO DUTY:

_____

_____

_____

_____ _____ _____

Physician's Name (Printed) Physician's Signature Date