WORKER'S COMPENSATION

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

EMPLOYER NAME: GREEN COUNTY

CLAIM NUMBER:

PATIENT NAME:

DATE OF INJURY:

TO BE COMPLETED BY **ATTENDING PHYSICIAN** - PLEASE CHECK

DIAGNOSIS/CONDITION
(BRIEF EXPLANATION)

I SAW AND TREATED THIS PATIENT ON _____ (DATE) AND BASED ON THE ABOVE DESCRIPTION OF THE PATIENT'S CURRENT MEDICAL PROBLEM:

1. ☐ RECOMMEND HIS/HER RETURN TO WORK WITH NO LIMITATIONS ON: _____ (DATE).

2. ☐ HE/SHE MAY RETURN TO WORK ON: _____ (DATE) CAPABLE OF PERFORMING THE DEGREE OF WORK CHECKED BELOW WITH THE FOLLOWING LIMITATIONS:

☐ **SEDENTARY WORK**. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involved sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **LIGHT WORK**. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree of when it involved sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **LIGHT MEDIUM WORK**. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **MEDIUM WORK**. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **MEDIUM HEAVY WORK**. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **HEAVY WORK**. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8-hour work day, the patient may:
   a. Stand/Walk
      ☐ NONE ☐ 1-4 Hours ☐ 4-6 Hours ☐ 6-8 Hours
   b. Sit
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours
   c. Drive
      ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

2. Patient may use hand(s) for repetitive:
   ☐ Single Grasping
   ☐ Pushing or Pulling
   ☐ Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐ YES ☐ NO

4. Patient is able to:

	FREQUENTLY	OCCASIONALLY	NOT AT ALL
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS:

THESE RESTRICTIONS ARE IN EFFECT UNTIL: _____ (DATE) OR UNTIL THE PATIENT IS RE-EVALUATED ON: _____ (DATE).

3. ☐ HE/SHE IS TOTALLY INCAPACITATED AT THIS TIME. PATIENT WILL BE RE-EVALUATED ON: _____ (DATE).

NAME OF PROVIDER: DATE:

PHYSICIAN:

PHYSICIAN'S SIGNATURE:

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