



OFFICE OF HUMAN RESOURCES

PHYSICIAN REPORT
RETURN TO WORK EVALUATION

THIS FORM MUST BE RETURNED TO THE OFFICE OF HUMAN RESOURCES
PRIOR TO RETURNING TO WORK

Employee's Name: _____ Date: _____

Job Title: _____ Department: _____

Attending Physicians Report

(please check appropriate boxes below)

Date of last treatment: _____ Date of next follow-up appointment: _____

Diagnosis: _____

[] Patient may resume regular work duties as of this date: _____

[] Patient is unable to resume regular work duties:

[] Temporarily. [] Permanently.

[] Patient is able to work on modified duty as of this date: _____

o Patient is able to:

- Bend: [] Yes [] No
▪ Squat: [] Yes [] No
▪ Climb: [] Yes [] No
▪ Lift: [] Yes [] No

o Patient can lift up to: [] 20 lbs. [] 50 lbs. [] over 50 lbs.

o If hand/arm injury, patient can use hands for repetitive movements:

- Simple grasping: [] Yes [] No
▪ Pulling and pushing: [] Yes [] No
▪ Repetitive wrist motion: [] Yes [] No

o If foot injury, patient can use feet for repetitive movements:

[] Yes [] No

o Further details of modified duty:

o _____

Physician's Name: _____ Telephone #: _____

Physician's Signature: _____ Date: _____