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: _________________________

☐ Patient is able to:

☐ Bend: ☐ Yes ☐ No
☐ Squat: ☐ Yes ☐ No
☐ Climb: ☐ Yes ☐ No
☐ Lift: ☐ Yes ☐ No

☐ Patient can lift up to: ☐ 20 lbs. ☐ 50 lbs. ☐ over 50 lbs.

☐ 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

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

☐ Yes ☐ No

☐ Further details of modified duty:

_____________________________________________________________

Physician’s Name: ___________________________ Telephone #: ___________________________
Physician’s Signature: ___________________________ Date: ___________________________

2/6/14 revised