RELEASE TO RETURN TO WORK

Employee ID #:_____ Employee Name:_____

The above named individual was examined on: _____ I certify that from _____ to _____ this individual was unable to perform the physical requirements of his/her work.

IF PATIENT IS NOT TOTALLY RELEASED TO FULL DUTY AS OF THIS DATE, PLEASE COMPLETE THE FOLLOWING INFORMATION INDICATING ANY LIMITATIONS:

Number of hours per □ day or □ week patient is able to work _____.

Temporary Physical Limitations: (No comment indicates no limitation)
C = Continuous, no limit, 66% to 100% of the day
F = Frequently, 34%-65% of the day
O = Occasionally, up to 33% of the day
N = Not OK

Capabilities	C	F	O	N	Lifting	C	F	O	N
Bend					0-10 lbs.				
Squat					11-20 lbs.				
Crawl					21-40 lbs.				
Twist					41-60 lbs.				
Reach above shoulders					Over 60 lbs.				
Walk ramps					Use arms/repeated pushing/pulling				
Use stairs/steps/step-stools					Use arms/repeated grasp/lift/carry				
Use ladders					Use hands/repeated fine manipulations				
Run/walk on rough/uneven surfaces					Carry: (maximum: lbs. Ok?)				
Run or jog up to 200 yards									
Push or pull loads up to 175 lbs									
Pull, drag, or carry loads with an average weight of 162 lbs. for a distance up to 40 yards									

Endurance:
Please indicate below the number of hours these activities should be limited too.

HOURS	1	2	3	4	5	6	7	8
Sitting								
Standing								
Walking								

Date patient is able to return to work full time with **NO** limitations: _____.

Additional comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

Physicians/ Practitioner's Name (Print): _____

Signature: _____ Date: _____

Address/Telephone: _____

Type of Practice (Field Specialization):_____

_____

PLEASE RETURN COMPLETED RELEASE TO THE PATIENT OR MAIL/FAX TO:

City of Salem
Human Resource Department
555 Liberty St. SE, Room 225
Salem, OR 97301

Confidential Fax:
503-588-6170, Attn: Human Resources

Telephone: 503-588-6162