



Office of Human Resources and Strategic Talent Management

Physical Capabilities Worksheet (Return to Work) Form

Physician Response: Please complete this form after your examination of the patient and their specific job description. Indicate the patient’s restrictions, if any, including modified hours, duties, environmental factors and any other information pertinent to this employee’s healthy recovery and possible early return to work. **I have read the patients job description (initials):** _____

Patient Name: _____ Date of Injury (if applicable): _____

Diagnosis: _____

- Employee may return to work without restrictions on: _____
- Employee is not released to work in any capacity
- Employee may return to work with the following restrictions:

Lifting/Carrying	Never	Occasionally	Frequently	Pushing/Pulling	Never	Occasionally	Frequently
1 – 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 – 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 – 49 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26 - 49 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No lift/carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No push/pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Never	Occasionally	Frequently
Bending/stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting/kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping/squeezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs/ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Instructions (if any):

Length of Restrictions: Start _____ End _____

Physician Printed Name _____ Telephone _____

Physician Signature _____ Date _____