Physician, please complete & return this form to the employee to assist us in accommodating any temporary work restrictions.

Date of work-related injury/illness: ____/____/___ Date of appointment: ____/____/___

Patient's name: _____

Patient is expected to return to full duty: ____/____/___ modified duty: ____/____/___

In an 8 hour work day, the employee can:

Activity/Duration	1-3 hours	3-5 hours	5-8 hours	Not at all
Stand				
Walk				
Sit				
Stoop/Squat				
Reach				
Lift/Carry	Under 11 lbs.	11 to 25 lbs.	25 to 50 lbs.	Over 50 lbs.

Employee is able to safely:

Activity/Duration	Frequently	Occasionally	Not at all
Work on Stairs			
Climb			
Work from a Ladder			
Drive a Vehicle			
Operate Machinery			
Answer Phones			
Bend/Kneel			
Reach to Shoulder			
Overhead Work			
Push/Pull/Grasp			
Fine manipulation			
Keyboard			
Handle Files			
Handle Chemicals			
Lift			
Carry			

Employee is capable of using reason to perform:

Activity/Duration	Frequently	Occasionally	Not at all
Reading			
Strong Analytical Skills			
Computer Skills			
Customer Interaction			
Communication (Writing; Verbal; Listening)			
Attention to Detail (Multiple Stimuli)			
Manage Multiple Priorities			

List all other restrictions on additional pages, if necessary. Please be specific.
(i.e., environmental restrictions such as dust; grease; noise; heat; etc.)

Maximum limits on employee's ability to work: hours p/day____ days p/week____

May employee work overtime?

Date of next appointment: ____/____/___ Yes No

Physician signature: _____Date: ____/____/___