City of Palmer
Return to Work Form
Fax (907) 761-1322
Phone (907) 761-1302

Completed form is to be returned to employer following each patient visit.

Employee's Name: _____ Appt. Date: _____

ID/SSN: _____ Date of Injury: _____ Division/Dept: _____

Brief diagnosis of injury/illness:
_____
_____

RETURN TO WORK STATUS

Please review the attached job description and assess the employee's ability to complete the job functions listed therein

Release: (check only one)

1. _____ Patient is unable to return to work.
2. _____ **Full duty release without temporary restrictions:** employee can work full duty without restrictions
3. _____ **Light duty release with temporary restrictions**: employee can return to Light Duty Work with the following temporary restrictions: (COMPLETE RESTRICTIONS SECTION)
4. _____ Will medication use prohibit driving or operation of heavy equipment? Yes __ No __

Restrictions: (check all that apply and fully describe below)

_____ No Restrictions _____ Temporary Restrictions _____ Permanent Restrictions

1. _____ Restricted lifting/carrying (maximum weight in pounds) _____ other _____ frequency _____
2. _____ Restricted pushing/pulling of _____ lbs.
3. _____ Restricted reaching: above chest _____ overhead _____ away from body _____ other _____
4. _____ Restricted to one-handed duty. No use of: right hand _____ left hand _____
5. _____ Restricted: walking _____ standing _____ sitting (describe) _____ partial wt bearing (describe) _____
6. _____ Wear splint at: all times _____ work _____ at night (describe) _____
7. _____ DO NOT: Operate Machinery _____ Crawl _____ Kneel _____ Squat _____ Drive any vehicle _____ Climb _____ Bend _____ Stoop _____

In my opinion, these restrictions or limitations are:

____ Temporary: ____ Days ____ Less than 2 weeks ____2 to 4 weeks ____ 4 to 6 weeks

____ 6 weeks to 3 months ____ More than 3 months ____ Permanent

Patient requires follow up treatment on:

Date: _____ Time: _____

Medications:

_____

Notes to physician:

1. This form is not intended for Workers' Compensation Board purposes. For a work-related injury or illness, the required WCB forms must be completed.

2. This form DOES NOT replace forms related to an employee's ability to work that are required by WCB, third-party insurers or any other plans.

Physician's notes: _____

Physician's Signature: _____ Date: _____

Address: _____