UAMS

Return to Work Form

Patient / Employee Information			
Patient / Employee Name:		**Employee ID #:**	
Date of Condition / Injury:		**Diagnosis/Treatment:**	

Patient (employee) is responsible for returning COMPLETED FORM to their immediate supervisor, on or before return to work date. Method: In person, fax, or email

TO BE COMPLETED BY ATTENDING PHYSICIAN

☐ Employee may return to work with no restrictions on _____ *(date)*.

☐ Employee may return to work with the following restrictions listed below. Restrictions are in effect from _____ to _____ *(dates only)*.

Patient ***CAN*** Carry/Lift			
	None	**1-4 HRS**	**5-8 HRS**
UP TO 10 LBS.			
11-20 LBS.			
21-50 LBS.			
51-100 LBS.			

Hand Restrictions				
HAND RESTRICTIONS	**NO USE**	**USE RIGHT ONLY**	**USE LEFT ONLY**	**USE BOTH**
OPERATE POWER TOOLS				
REPETITIVE WRIST				
ONE HAND WORK ONLY				

Patient's condition ALLOWS them to perform the following activities. (How many hrs. each day)			
	1-4 HRS	**5-8 HRS**	**No Restrictions**
BEND			
TWIST/TURN			
REACH BELOW KNEE			
PUSH/PULL			
CLIMB			
SQUAT/KNEEL			
***Must* SIT**			
STANDING			
WALKING			

☐ Employee is totally disabled and may not return to work from _____ to _____ *(dates)*.
Explanation:_____
_____

☐ Is the employee on any prescriptions that may cause them any physical or mental impairment that may affect the employee's ability to perform their job? ☐ No ☐ Yes,

> Please indicate Medication(s)_____
> Other Restrictions _____
_____

Physician Information			
Physician Name:		**Clinic / Facility Name:**	
Signature & Date:		**Clinic / Facility Phone #:**	

Please return the completed form to the employee.