MEDICAL RETURN TO WORK EVALUATION
WORK INJURY/ILLNESS

The Treating PHYSICIAN must complete this form each time employee is treated

Patient/Employee Name: ________________________________ **Date:** ________________

Work/Job/Position: ________________ **Department:** ______________ **Date of Injury / Illness:** __________

TO BE COMPLETED BY PHYSICIAN

1. Is the employee able to perform his/her regular work without restriction? ☐ Yes ☐ No

If Yes, indicate date employee can return to regular work:______________________
If No, complete #2:

2. Is the employee able to perform Light Duty assignments? ☐ Yes ☐ No
If yes, check the workplace limitations below that are due to the injury.

Number of hours a day employee is able to work: ________________

Type of Work	No Restriction	Partial Restriction	Full Restriction
Sedentary – Lifting 0 – 10 Pounds			
Light – Lifting 10 – 20 Pounds			
Moderate – Lifting 20 – 50 Pounds			
Heavy – Lifting 50 – 100 Pounds (Occasional)			
Pulling / Pushing / Carrying			
Reaching or Working Above Shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Repeated Bending and Crawling			
Climbing			
Operating a Vehicle, Truck, Etc.			

Exposure Limitations: ☐ Heat ☐ Cold ☐ Dust ☐ Fumes

3. Diagnosis of Injury, Treatment Plan, and Prognosis: ______________________________

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Next Appointment: __________ **Has Employee Reached MMI?** ______ **Discharged?** ______

Physicians Signature: ______________________ **Date:** __________

Printed Name: ______________________ **Clinic Name:** ____________________