Jordan School District Human Resources

Return to Work Release

Your cooperation in completing this form is time sensitive and vital to our efforts in determining the work potential of your patient. Our goal is to return the Jordan School District employee to his/her full working capacity as soon as possible. **Thank you for your assistance.**

Note to the EMPLOYEE: If you are returning with restrictions, you need to communicate with your HR Generalist to determine if reasonable accommodations(s) can be made for you to return to work. You must contact the HR Generalist as soon as restrictions are known to ensure appropriate planning can take place; we request a minimum of 3 contract days. **Failure to submit this form may delay or prevent your ability to return to work.**

Please Print	Employee's Name: _____	
I have reviewed the job description : ☐ **Yes** ☐ **No** ☐ **NA**	First day of leave: _____	Date of Exam: _____
Diagnosis or description of injury/surgery/illness: _____		

Work Status Information

☐ Return to regular duty ***without restrictions (list below)***	Date: _____	**Follow up treatment plan**
☐ Able to return to work ***with restrictions***	Date: _____	☐ None
Anticipated length of restrictions: _____		☐ Return visit(s)
☐ **Unable to return** to work until next evaluation	Date: _____	Date: _____
☐ Unable to return ***within 180 days of first day of leave***	Date: _____	Time: _____ am/pm
☐ **Referred** to another healthcare provider	Date: _____	Date: _____
Specialty/anticipated treatment : _____		Time: _____ am/pm

Physical Restrictions and Limitations

Lifting restrictions:

- ☐ *No Restriction*
- ☐ *More than 50 lbs*
- ☐ *30-50 lbs*
- ☐ *20-30 lbs*
- ☐ *10-20 lbs*
- ☐ *less than 10 lbs*

☐ Must use specialized equipment (such as scooter, crutches, or other)

Please Specify: _____

_____

_____

The patient's physical restrictions or limitations:		**None** 0% of the workday	**Occasionally** 1-33% of the workday	**Frequently** 34-64% of the workday	**Constantly** 65-100% of the workday
☐ Lifting floor to waist	L/R **(circle)**	☐	☐	☐	☐
☐ Lifting waist to shoulder	L/R **(circle)**	☐	☐	☐	☐
☐ Lifting/reaching above shoulder	L/R **(circle)**	☐	☐	☐	☐
☐ Pushing/pulling, max _____ lbs		☐	☐	☐	☐
☐ Twisting of upper body		☐	☐	☐	☐
☐ Standing/walking **(Limit to _____ hours a day)**		☐	☐	☐	☐
☐ Repetive bending/stooping		☐	☐	☐	☐
☐ Grasping/squeezing	L/R **(circle)**	☐	☐	☐	☐
☐ Repetitive wrist movement	L/R **(circle)**	☐	☐	☐	☐
☐ Keyboarding		☐	☐	☐	☐
☐ Squatting, kneeling or crawling		☐	☐	☐	☐
☐ Climbing stairs/ladders		☐	☐	☐	☐

Able to drive vehicle for work purposes, if applicable: ☐ Yes ☐ No ☐ NA

Cognitive/Mental/Behavioral Limitations

Diagnosis or description of cognitive/mental/behavioral condition: _____

Please Identify any other job-related cognitive/mental/behavioral limitations: (If None, please write Not Applicable)_____

Additional comments: _____

_____

_____

Healthcare provider's signature

Date Signed

Health care provider's name **(please print)**

Phone number **(include area code)**

Specialty

Address

Please fax a copy of this complete form to our HR Generalist: 801-567-8056 Attn: Jane Olsen Thank you for your assistance.

Last Updated 2/2019