RETURN TO WORK
MEDICAL EVALUATION FORM

NOTE TO PHYSICIAN: We need your assistance in protecting the health and wellbeing of the patient listed below. Your answers will help determine whether the employee needs to **1)** be away from work for further rehab and/or recovery, or **2)** if they could return – upon supervisor's agreement, on a restricted basis, or **3)** if they have been fully cleared by you and it has been determined they can resume their responsibilities with no restrictions or alterations to their work day and workplace, based on the job description provided. Please answer the following questions to the best of your knowledge.

Name of Patient _____

Date of injury/surgery/onset of illness_____ **Date of Exam** _____

Diagnosis/description of injury/surgery/illness_____

The patient's return to work status is:

___ Return to regular work. Effective _____

___ Able to return to work with noted restrictions. Effective _____

___ Unable to return to work until next evaluation, scheduled for _____

___ Referred to another health care provide for additional evaluations – please provide name of health care provider _____

Lifting Restrictions:

___ NONE _____ 10 - 19 lbs ___ 20 -29 lbs ___ 30 – 39 lbs ___ 40 – 50 lbs

Follow-up Plan of Treatment:

___ NONE
___ Return visit on _____ at _____ am/pm

Additional comments:

_____

_____

_____

Signature of physician Printed Name Date

_____

Office Address Office Phone Number