PIERCE COLLEGE DISTRICT

www.pierce.ctc.edu

RELEASE TO RETURN TO WORK FORM

Employee's Name:	**Date:**
Health Care Provider's Name and business address:	

Instructions:

Employee: Have your health care provider review your job description and ask him/her to complete this form. Return the completed form to the **Human Resources** office ***before*** you return to work.

Required: Released for work? *Check at least one*

☐ Worker is released **without restrictions** as of (date): ____/____/____ (*If selected, skip to "Signature" section below)*

☐ The above named employee has been released by the above named physician to Return to Work on ____/____/____ (Date) WITH THE FOLLOWING RESTRICTIONS through ____/____/____ (Date) (If selected, please estimate capacities below)

Required: Estimate what the worker can do unless released without restrictions.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach **L**eft, **R**ight, **B**oth					
Work above shoulders **L, R, B**					
Keyboard **L, R, B**					
Wrist (flexion/extension) **L, R, B**					
Grasp (forceful) **L, R, B**					
Fine manipulation **L, R, B**					
Operate foot controls **L, R, B**					
Vibratory tasks; high impact **L, R, B**					
Vibratory tasks; low impact **L, R, B**					

Lifting / Pushing	**Never**	**Seldom**	**Occas.**	**Frequent**	**Constant**
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift **L, R, B**	____ lbs	____ lbs	____ lbs	___ lbs	____ lbs
Carry **L, R, B**	____ lbs	____ lbs	____ lbs	___ lbs	____ lbs
Push / Pull **L, R, B**	____ lbs	____ lbs	____ lbs	___ lbs	____ lbs

Other Restrictions/Instructions:

Sign

Medical Professional's Signature Date