



Return to Work Medical Assessment

Employee Name: _____ Date of Injury/Illness: ___/___/___

Examination/Treatment Date: ___/___/___

Injury Diagnosis Summary:

Return-to-Work Considerations:

1. _____ Return to work immediately with NO restrictions.
2. _____ Return to work with restrictions checked below; beginning ___/___/___ and ending ___/___/___
3. _____ No return to work until ___/___/___

Next Scheduled examination/treatment: ___/___/___

No. of consecutive hours the patient can perform the specified activity during 8-hr Period

Weight Handling Frequencies

# of Hours	6-8	4-5	1-3	0
Sitting				
Standing				
Walking				
Pushing				
Pulling				
Climbing				
Bending				
Kneeling				
Reaching				
Grasping				

# of Times/Hour	15 +	10-15	1-10	0
Lifting or Carrying: Less than 10 lbs.				
10-20 lbs.				
20-35 lbs.				

Number of consecutive hours the patient can perform the above weight handling frequencies during an 8-hr. work period:

Prescription Medication Required? Y or N

Additional Instruction or Comments:

Physician's Name: _____ Physician's Signature: _____

Phone: 757-824-1266

FAX: 757-824-1497