

Physician's Return To Work Instructions

Form P-2

Patient Name: _____

- Cannot Return To Work due to Restrictions / Risk of Injury to Self or Others
 Cannot Return To Work due to Pain Intolerance
 Released to Return To Work Modified Duty with Limitations Full Duty without Limitations

During ____ hours, the patient is released to perform:

	Continuously	With Rest
Sit	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>

Lift:	Never	Occasionally (33%)	Frequently (34-66%)	Continuously (67-100%)
10lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Carry:	Never	Occasionally (33%)	Frequently (34-66%)	Continuously (67-100%)
10lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Bend:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Handling:	Simple Grasping		Fine Manipulation	
Right Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Pushing and Pulling:	Light		Medium		Heavy	
Right Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Activity Restrictions Involving:	Total	Moderate	Mild	No Restrictions
Fixed / Moving Machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Restrictions / Limitations effective through: _____ Date: ____/____/____

Special Instructions (Restrictions and/or Limitations): _____

Physician's Signature: _____ Date: ____/____/____