WEBER STATE UNIVERSITY
Human Resources
1016 University Circle
Ogden, UT 84408-1016
801-626-6032 Fax: 801-626-6925

EMPLOYEE'S RETURN TO WORK FORM

Must be completed legibly by physician

Patient's Name: _____ Date of Onset: _____

Date(s) of Treatment: _____

History: _____

Name(s) of other physician(s) or medical providers who have served on case: _____

_____

Diagnosis: _____

Treatment (Proposed or completed): _____

Medication(s): _____

Prognosis: _____

First day off work: _____ **Estimated** return to work date: _____

Actual Return to Work **without** restrictions: _____

Return to work **with** reduced schedule:

Number of hours per day: _____ Number of days per week: _____

Beginning: _____ Ending: _____

☐	Return to work with the following restrictions:	Beginning: _____			Ending: _____	
☐	Lifting (weight)	0-10 lbs.	11-25 lbs.	26-40 lbs.	41-50 lbs.	over 50 lbs.
	Lifting					
	From Floor	25%	50%	75%	100%	
	From waist level	25%	50%	75%	100%	
	Over the shoulder/head	25%	50%	75%	100%	
☐	Pushing/pulling (weight)	0-10 lbs.	11-25 lbs.	26-40 lbs.	41-50 lbs.	over 50 lbs.
☐	Pushing/pulling frequency	25%	50%	75%	100%	
☐	Standing	25%	50%	75%	100%	
☐	Sitting	25%	50%	75%	100%	
☐	Walking	25%	50%	75%	100%	
☐	Climbing	25%	50%	75%	100%	
☐	Bending 18"from body	25%	50%	75%	100%	
	From shoulder level	25%	50%	75%	100%	
	Over the head	25%	50%	75%	100%	
☐	Kneeling/Squatting	25%	50%	75%	100%	
☐	No operating moving machinery					
☐	No Driving					

Additional instruction: _____

_____

Date of next office visit: _____

Physicians Name: _____

City, State, Zip: _____

Telephone Number: _____ Fax Number: _____

Physician's Signature: _____ Date: _____