# RETURN TO WORK FORM

Employee Name: ______________________________ Job title: ______________________________

Company: ________City of Trenton________ Supervisor: ___________________________

Location: ______________________________ Supervisor's Phone: ____________________

Date of Injury/Illness: ___________________

Describe Injury/Illness: ______________________________________________________________

**Below to be completed by Physician**
**PLEASE CHECK ONE AND ANSWER QUESTIONS AS APPLICABLE:**

I most recently evaluated this employee on (date) _______________ and certify that:

☐ Employee is able to return to full, unrestricted work activities and is able to perform the essential job functions of his or her job as set forth in the attached job description as of (date) _________.

☐ Employee is medically stable to perform work activities that are compatible with his or her restrictions. Medical status will be re-evaluated on (date) __________. This employee should be initially assigned to daily work activities that will not exceed the following restrictions/abilities:

| STAND/WALK | SITTING | RIGHT ARM USE | LEFT ARM USE |
|---|---|---|---|
| ☐ UNLIMITED | ☐ UNLIMITED | ☐ UNLIMITED | ☐ UNLIMITED |
| ☐ 7-8 HOURS | ☐ 7-8 HOURS | ☐ 7-8 HOURS | ☐ 7-8 HOURS |
| ☐ 5-6 HOURS | ☐ 5-6 HOURS | ☐ 5-6 HOURS | ☐ 5-6 HOURS |
| ☐ 3-4 HOURS | ☐ 3-4 HOURS | ☐ 3-4 HOURS | ☐ 3-4 HOURS |
| ☐ 1-2 HOURS | ☐ 1-2 HOURS | ☐ 1-2 HOURS | ☐ 1-2 HOURS |
| ☐ NONE | ☐ NONE | ☐ NONE | ☐ NONE |

| OCCASIONAL LIFTING | FREQUENT LIFTING | OPERATION OF FOOT CONTROLS | OTHER RESTRICTIONS/ FUNCTIONAL ABILITIES |
|---|---|---|---|
| ☐ UNLIMITED | ☐ UNLIMITED | ☐ UNLIMITED | ☐ __________________ |
| ☐ 7-8 HOURS | ☐ 7-8 HOURS | ☐ 7-8 HOURS | |
| ☐ 5-6 HOURS | ☐ 5-6 HOURS | ☐ 5-6 HOURS | ☐ __________________ |
| ☐ 3-4 HOURS | ☐ 3-4 HOURS | ☐ 3-4 HOURS | |
| ☐ 1-2 HOURS | ☐ 1-2 HOURS | ☐ 1-2 HOURS | ☐ __________________ |
| ☐ NONE | ☐ NONE | ☐ NONE | |

☐ Employee is medically unstable and unable to perform any work activities (even on a part-time basis) at this time. Medical status will be re-evaluated on (date) _____________.

If the employee is taking prescribed medications, can the employee safely perform the essential job functions of their positions? ☐ Yes ☐ No

Does the employee have any functional restrictions based on mental conditions? ☐ Yes ☐ No
Note: **IF YES IS INDICATED, PLEASE REFERENCE THE RETURN TO WORK MENTAL HEALTH FORM AS NEEDED.**

**Restrictions in effect until:** _________ **(DATE)** **Next appointment on:** ______________ **(DATE)**

**Physician Contact Information:** ________________________________________________

_____________________________________________________________________________

________________________ ________________________ ______________
Physician Signature Printed Name Date

**PLEASE EMAIL THIS FORM IMMEDIATELY TO THE CITY MANAGER'S OFFICE: sleichman@ci.trenton.oh.us**