Human Resources Division
Benefits Department
190 Sailstar Drive NW, Cass Lake, MN 56633
(218) 335-3698 Phone • (218) 335-3697 Fax

PLEASE NOTE:
This form must be returned within 72 hours of doctor visit.

Return to Work Form

Employee Name: _____ Social Security #: _____

Division: _____ Department: _____

Program:_____ Position:_____

If accident, date of injury: _____

The following must be completed by the attending physician

Date of visit:_____

Describe disability condition/diagnosis and course of treatment *(please be detailed):* _____

_____

_____

_____

Can the patient return to work **without restrictions**? ☐ Yes ☐ No

If yes, date patient can return to work: _____

If patient **cannot return to work**, what is the anticipated return date?_____

If patient cannot return to work, please list reasons:_____

_____

_____

_____

If patient **can return to work with restrictions**, please answer the following questions:

Return to work date: _____

In an 8-hour work day, can the patient:

	Yes	No	If yes, maximum number of hours
Stand			
Walk			
Sit			

Does the patient have lifting restrictions? ☐ Yes ☐ No

If yes, please indicate maximum weight lifting restrictions: _____

Please list any other restriction that may apply to lifting, i.e. carrying, pushing or pulling of objects:

_____

_____

_____

Return to Work Form Continued

In an 8-hour work day patient may *(check all that apply):*

	Not at all (0-33%)	Occasionally (33-66%)	Frequently (66-100%)
Bend/stoop			
Squat/kneel			
Reach			
Twist			
Climb stairs			
Sweep/mop			
Vacuum			
Stretch			

In an 8-hour work day patient may use repetitive motion with their hands *(check all that apply):*

	Not at all (0-33%)	Occasionally (33-66%)	Frequently (66-100%)
Gripping objects			
Carrying objects			
Lifting small objects			
Writing/typing			
Pushing/pulling			
Fine manipulation			

List any other work restrictions and/or limitations that may apply: _____

_____

_____

_____

The above restrictions/limitations are in effect until: _____

Does the patient require follow up care? ☐ Yes ☐ No

If yes, date of next schedule appointment: _____

Additional Comments: _____

_____

_____

Physicians Signature: _____ Date: _____

Physicians Name *(please print)*: _____ Phone Number: _____

Clinic Address: _____