Leech Lake Health and Safety Department
6280 Upper Cass Frontage Rd NW, Cass Lake, MN 56633

Reporting Workplace Injuries
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Fax: 218-335-7070

Return to Work Form

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

Employee Name:_____ Social Security #:_____

Division:_____ Department:_____

Program:_____ Position:_____

If accident, date of injury:_____

The following must be completed by attending physician:

Date of visit: _____

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

_____

_____

_____

_____

Can 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 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	Occasionally	Frequently
Bend/stoop			
Squat/kneel			
Reach			
Twist			
Climb stairs			
Sweep/mop			
Vacuum			
Stretch			
	(0-33%)	(33-66%)	(66-100%)

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

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

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 scheduled appointment: _____

Additional Comments:

_____

_____

_____

_____

Physicians Signature_____ Date_____

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

Clinic Address_____