ATTENDING PHYSICIAN STATEMENT
RETURN TO WORK FORM
GEAUGA COUNTY COMMISSIONERS
470 Center Street, Building #4, Chardon OH 44024
Phone: 440-279-1670, Fax: 440-286-9177

Patient Name		Date	
Date of Injury	If applicable, BWC Risk #: 32800001	Time In	Time Out
DIAGNOSIS:		_____ Initial Visit	_____ Follow-up

Summary of Findings

Return to work with no limitations	Date:	Next scheduled work shift
Return to work with limitations	From:	To:
Totally Disabled for Work	From:	To:

Work Limitations In an 8 Hour Work Day

Patient Can Lift/Carry	Cannot DoAt All	Can do Occasionally 1%-33%	Can do Frequently 34%-66%	Can do Continuously 67%-100%
Up to 10 pounds	_________	____________	__________	___________
11-20 pounds	_________	____________	__________	___________
21-50 pounds	_________	____________	__________	___________
51-100 pounds	_________	____________	__________	_______
LIMIT THE FOLLOWING ACTIVITIES				
Bend	_________	____________	__________	___________
Twist/Turn	_________	____________	__________	___________
Reach below knee	_________	____________	__________	___________
Push/Pull Wt. _____#	_________	____________	__________	___________
Climb	_________	____________	__________	___________
Reach above shoulder	_________	____________	__________	___________
Squat/Kneel	_________	____________	__________	___________
Stand or Walk	_________	____________	__________	___________
Sit	_________	____________	__________	___________
Drive company vehicle	_________	____________	__________	_
LIMIT THE FOLLOWING HAND ACTIVITIES: PLEASE CIRCLE - RIGHT LEFT BOTH				
Operate power or	________	____________	__________	___________
vibrating tools	________	____________	__________	___________
Torquing, crimping	________	____________	__________	___________
Repetitive wrist motion	________	____________	__________	_______

Additional Limitations

___Change positions every:___ half hour or _______ hours
___ Patient must wear splint/bandage during work activities
___ Keep wound clean and dry.
___ Patient may not use: ___ Right arm/hand ___ Left arm/hand
____ Unable to perform duties requiring depth perception or using high speed machinery
____ May/may not wear rubber/cotton/leather glvs
____ No unguarded machinery or work in which dressing/appliance a safety hazard
____ Avoid: ___ fumes ___ irritants ___ chemical aerosols/
Contact: ___ heat ___ cold
____ No incentive oriented duties
____ Medication prescribed: ____ May be taken at work ____ May not be taken at work

ADDITIONAL COMMENTS

Physician Signature **Physician Name** **Date**

Patient Referred to Physical Therapy:
Referred to:______________________________
Address & Phone: _______________________
____
Appointment Date/Time: ______________________

Patient Referred to a Specialist:
Referred to: _________________________________
Address & Phone: ___________________________
____
Appointment Date/Time: ______________________

TREATMENT PLAN **Next Appointment Date:** **Time:**

G For your reference, a job description is attached.

HEALTH CARE PROVIDER INFORMATION

Attached to this *Health Care Provider Information* form is the current description of the essential functions of the position occupied by ____________(employee name), including the physical and mental demands of the job. Please answer the following questions regarding the employee=s condition as it relates to the essential functions and possible accommodations.

G What is _____________________________medical condition?

G How long has he/she had this condition?

G Is the condition temporary or permanent?

G How is this condition being treated? If medication is provided, what is the effect of the medication on the employee and does the medication control the effects of the condition?

G Does the condition affect the employee=s ability to perform any of the essential function of the position?
For your reference, a copy of the position description is being provided.
If yes, please describe how the condition affects the person=s ability to perform his/her specific job functions.

G What, if any, restrictions have you placed on the employee?

G Do any of these restrictions preclude the employee from performing the essential functions of his/her job?

Continued on Reverse

- Does the employee experience any limitations in any major life activities such as walking, talking, seeing, speaking, working, caring for oneself, breathing, etc.?

- In your opinion, what are some ways in which the employer might be able to allow the employee to perform all of the essential functions of his/her job?

- Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

______________________________	______________________________
Provider Name (please print)	Professional License or Specialty
______________________________	______________________________
Signature	Date

With employee authorization, the Health Care Provider may return this form directly to:

Geauga County Commissioners
Attn: Confidential to Linda Burhenne
470 Center Street, Building #4
Chardon, OH 44024-1071

FAX NUMBER: _FAX 440-286-9177____________
PHONE NUMBER: ___440-279-1671___________
E-MAIL: __lburhenne@co.geauga.oh.us___________

ATTACHMENTS:
- Attending Physician Statement
- Job Description
- Job Analysis – if available