ATTENDING PHYSICIAN STATEMENT
RETURN TO WORK FORM

GEAUGA COUNTY COMMISSIONERS
470 Center Street, Building #4, Chardon OH 44024
Phone: 440-285-2222, Fax: 440-286-9177

Patient Name	Date
Date of Injury If applicable, BWC Risk #: 32800001-0	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 LIFT/CARRY LIMITATIONS	CANNOT Do At 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	_____	_____	_____	_____
LIMITATIONS ON 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 COMMENTS

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

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:**

¨ 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.

1. What is _____medical condition?

¨ How long has he/she had this condition?

¨ Is the condition temporary or permanent?

2. 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?

3. 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.

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

5. Do any of these restrictions preclude the employee from performing the essential function of his/her job?

Continued on Reverse

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

7. 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?

8. 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:

Kathleen K. Hostutler
Geauga County Commissioners
470 Center Street, Building #4
Chardon, Ohio 44024

khostutler@co.geauga.oh.us
440-279-1672 Phone
440-279-1317 Direct Fax

ATTACHMENTS:

- ¨ Attending Physician Statement
- ¨ Job Description
- ¨ Job Analysis – if available