BCRC
BE PART OF SOMETHING

RETURN TO WORK FORM

TO BE COMPLETED BY INJURED/ILL WORKER

Date of Visit _____ Date of Injury/Illness _____ Social Security # _____

Employee Name _____ Birth Date _____

Address _____ Phone ( ) _____

City _____ State _____ Zip _____

TO BE COMPLETED BY PHYSICIAN/HOSPITAL STAFF ☐ Initial Treatment ☐ Follow-Up visit

WORK STATUS: ⬇

☐ **Employee may return to work on _____ with modified duties *as listed below*, effective until** _____

- ☐ No lifting over _____lbs.
- ☐ No work above ground or surface level
- ☐ No pushing or pulling over _____ lbs.
- ☐ No work around high speed or moving machinery
- ☐ No kneeling or squatting
- ☐ No standing more than _____ at a time
- ☐ Other:
- ☐ No walking more than _____ at a time
- ☐ No reaching above shoulder level
- ☐ No repetitive bending or twisting
- ☐ No sitting more than _____ at a time
- ☐ No operating mobile equipment
- ☐ No climbing of stairs or ladders
- ☐ No driving of motor vehicle

_____

_____

_____

☐ **Employee may return to full work duties on _____ with no restrictions or limitations.**

RECHECK: Employee will be rechecked by physician on _____, 20____ @ Time: _____a.m./p.m.

RECOMMENDATIONS: _____

_____

_____

_____

PHYSICIAN'S SIGNATURE _____ Date _____

PHYSICIAN'S NAME (printed) _____