Olathe Public Schools USD 233

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	Date:
Physician's Name:	Telephone #:

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _____ (Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) WITH THE FOLLOWING RESTRICTIONS:

Check applicable boxes and provide limitations/restrictions.	
□ Lifting (Max weight in lbs)_____lbs.	□ Walking _____hours per day
□ Repetitive Lifting_____lbs.	□ Standing_____hours per day
□ Carrying_____lbs.	□ Sitting _____hours per day
□ Pushing/pulling_____lbs.	□ Crawling_____hours per day
□ Pinching/Gripping_____lbs.	□ Kneeling_____hours per day
□ Reaching over head	□ Squatting_____hours per day
□ Reaching away from body	□ Climbing_____hours per day
□ Repetitive Motion Restrictions:	
□ Other Restrictions:	
These limitations/restrictions are:	□ Temporary limitations/restrictions through_____. □ Permanent limitations/restrictions

IF THE ABOVE RESTRICTION CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK.

My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's ability to perform the job duties.

Physician's Name (Please Print):			
Physician's Signature:		Date:	

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:		Date:	

RETURN TO FMLA / LOA SPECIALISTS at FAX 913-780-8008
14160 S. Black Bob Road Olathe KS 66063-2000