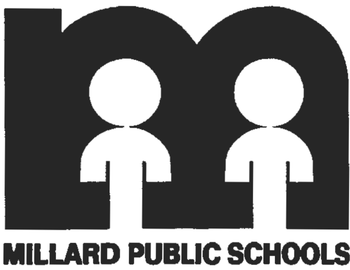

Please Return to Millard Public Schools
5606 S 147th St Omaha, NE 68137
PH: 402-715-8612 FAX: 402-715-1097
ATTN: Kim Coleman
fmla-wc@mpsomaha.org

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

(TO BE COMPLETED BY ATTENDING PHYSICIAN)

Patient's Name ______________________________ Date of Injury/Illness ____________________

DIAGNOSIS/CONDITION (Brief Explanation) ____

____

I saw and treated this patient on ______________(date) and based on the above description of the patient's current medical problem:

1. Recommend his/her return to work with no limitations on ________________.
   OR
2. He/She may return to work on ________________ (date) capable of performing the degree of work checked below.

CHECK ONLY AS RELATES TO THE ABOVE CONDITIONS

□ No Work.

□ Sedentary Work.
Lifting/carrying 10 pounds maximum and occasionally lifting.

□ Light Work.
Lifting/carrying 20 pounds maximum with frequent lifting.

□ Light Medium Work.
Lifting/carrying 30 pounds maximum with frequent lifting.

□ Medium Work.
Lifting/carrying 50 pounds maximum with frequent lifting.

□ Light Heavy Work.
Lifting/carrying 75 pounds maximum with frequent lifting.

□ Heavy Work.
Lifting/carrying 100 pounds maximum with frequent lifting.

1. In an 8 hour day patient may:
   a. Stand/Walk
      - □ None
      - □ 1-4 Hours
      - □ 4-6 Hours
      - □ 6-8 Hours
   b. Sit
      - □ 1-3 Hours
      - □ 3-5 Hours
      - □ 5-8 Hours
   c. Drive
      - □ 1-3 Hours
      - □ 3-5 Hours
      - □ 5-8 Hours
2. Patient may use hand(s) for repetitive:
   - □ Single Grasping
   - □ Pushing & Pulling
   - □ Fine Manipulation

Patient is able to:

	None	1-33% Occasionally	34-66% Occasionally	67-100% Occasionally
Bend				
Squat				
Climb				
Twist				
Reach				

These restrictions are in effect until the following date: ________________ or until patient is reevaluated.

Additional Comments: ____

PHYSICIAN'S SIGNATURE ______________________________ **DATE:** ________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative.

Patient's Signature ______________________________ Date ________________