RELEASE TO RETURN TO WORK

Employee ID #:

Employee Full Name:

Physicians/ Practitioners Full Name:

Type of Practice (Field of Specialization):

The above-named individual was examined on:

I certify that from to this individual was unable to perform the physical requirements of their work.

If the patient is not totally released to full duty, complete the following section.

Please complete the following information indicating any limitations:

- Number of hours per (☐ day / ☐ week) patient is able to work:

Temporary Physical Limitations: (No comment indicates no limitation)

C = Continuous, no limit, 66% to 100% of the day

F = Frequently, 34%-65% of the day

O = Occasionally, up to 33% of the day

N = Not OK

Capabilities	C	F	O	N	**Lifting**	C	F	O	N
Bend					0-10 lbs.				
Squat					11-20 lbs.				
Crawl					21-40 lbs.				
Twist					41-60 lbs.				
Reach above shoulders					Over 60 lbs.				
Walk ramps					Use arms/repeated pushing/pulling				
Use stairs/steps/stepstools					Use arms/repeated grasp/lift/carry				
Use ladders					Use hands/repeated fine manipulations				

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Run/walk on rough/uneven surfaces					Carry: (maximum: lbs.)				
Run or jog up to 200 yards									
Push or pull loads up to 175 lbs.									
Pull, drag, or carry loads with an average weight of 162 lbs. for a distance up to 40 yards									
Operate equipment of medium or heave construction									

Endurance:

Please indicate below the number of hours these activities should be limited to.

HOURS	1	2	3	4	5	6	7	8
Sitting								
Standing								
Walking								

Date patient is able to return to work full time with **NO** limitations:

Additional Comments:

Signature of Health Care Provider ____

PLEASE RETURN COMPLETED AND SIGNED FORM TO THE PATIENT OR MAIL/FAX/EMAIL TO:

City of Salem

Human Resources Division

295 Church St. SE Suite 210, Salem, OR 97301

Confidential Fax: 503-588-6170

protectedleave@cityofsalem.net