



Payroll and Benefits Office
RELEASE TO RETURN TO WORK
To be submitted to Human Resources PRIOR to return to work
 Confidential Benefits Fax: 425.385.4135

Name of Employee: _____ Employee ID #: _____

Released to return to work effective: _____ Restrictions: YES NO

IMPORTANT: Please complete the following items based on your clinical evaluation of the above captioned and other testing results. Any items that you do not believe you can answer should be marked N/A.

NOTE: In terms of an 8 hours workday, "Occasionally" = 1% to 33%, "Frequently" = 34% to 66%, "Continuously" = 67% to 100%

1. In an 8 hour workday employee can: (circle full capacity for each activity)

TOTAL AT ONE TIME (HOURS)											TOTAL DURING ENTIRE 8 HOUR DAY (HOURS)										
A. Sit	0	1/2	1	2	3	4	5	6	7	8	0	1/2	1	2	3	4	5	6	7	8	
B. Stand	0	1/2	1	2	3	4	5	6	7	8	0	1/2	1	2	3	4	5	6	7	8	
C. Walk	0	1/2	1	2	3	4	5	6	7	8	0	1/2	1	2	3	4	5	6	7	8	

2. Employee can lift:

	Never	Occasionally	Frequently	Continuously
A. Up to 5 lbs.				
B. 6-10 lbs.				
C. 11-20 lbs.				
D. 21-25 lbs.				
E. 26-50 lbs.				
F. 51-100 lbs.				

3. Employee can carry:

	Never	Occasionally	Frequently	Continuously
A. Up to 5 lbs.				
B. 6-10 lbs.				
C. 11-20 lbs.				
D. 21-25 lbs.				
E. 26-50 lbs.				
F. 51-100 lbs.				

4. Employee can use hands for repetitive action as:

- A. Simple Grasping
- B. Pushing & Pulling
- C. Fine Manipulating

Right Hand

Yes No
 Yes No
 Yes No

Left Hand

Yes No
 Yes No
 Yes No

5. Employee can use feet for repetitive movements as in operational functions:

Right Foot Yes No **Left Foot** Yes No **Both Feet** Yes No

6. Employee is able to:

	Never	Occasionally	Frequently	Continuously
A. Bend				
B. Squat				
C. Crawl				
D. Climb				
E. Reach above shoulder level				

7. Restrictions of:

	Never	Mild	Moderate	Total
A. Unprotected heights				
B. Being around moving machinery				
C. Exposure to marked changes in temperature and humidity				
D. Driving automotive equipment				
E. Exposure to dust, fumes and gases				

Duration of Restrictions:

_____ to _____

PERMANENT? YES NO

Comments: _____

Signature of Medical Provider

Printed Name of Medical Provider

Phone Number

Date