Everett Public Schools

Human Resources Department

RELEASE TO RETURN TO WORK

To be submitted to Human Resources at least three days 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:

		Right Hand		Left Hand	
A.	Simple Grasping	Yes	No	Yes	No
B.	Pushing & Pulling	Yes	No	Yes	No
C.	Fine Manipulating	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				

Duration of Restrictions:

_____ to _____

PERMANENT? YES NO

Comments: _____

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				

Signature of Medical Provider | Printed Name of Medical Provider | Phone Number | Date