St. Claire HealthCare

All Return to Work releases must be submitted to & approved by HR prior to returning to work.

RETURN TO WORK STATEMENT

Patient's Name: ______________________________ **SSN:** _______-_______-________

Return to full duties **without restrictions** on ____________________________.
DATE

Return to activities **with medical restrictions**.

Start Date: __________________________ End Date: __________________________ (**Required**)

Check all that apply: (**detail is required**)

No lifting greater than ______________lbs.

No use of hand(s): Right _______________ Left ________________ Both _____________

No use of arm(s): Right _______________ Left ________________ Both _____________

Sit down activities only.

Activity limited to: Splint ___________ Brace______________ Other_____________

Keep affected area clean and dry.

No repetitive bending and twisting.

No repetitive flexion / extension of Wrist(s): Right ___________ Left ___________ Both ___________

No over shoulder activity with Arm(s): Right ___________ Left ___________ Both ___________

Alternate Sitting/Standing every ____________ minutes ____________ hours.

Restrictions other than above:

____

____

Follow-up Appointment: ___________________

____ ________________________

Physician's Signature **Date**