RETURN-TO-WORK FORM

Employee Name:____________________________ Occupation/Job Title: ____________________________
Job description attached

Company: ______City of Hamilton______ Supervisor: ____________________________

Location: ____________________________ Supervisor's Phone: ____________________________

Date of Injury/Illness: ____________________________

Describe Injury/Illness:____

Below to be completed by Physician:

PLEASE CHECK ONE AND ANSWER QUESTIONS AS APPLICABLE:

I most recently evaluated this employee on (date) ____________________________ and certify that:

- ☐ Employee is able to return to full, unrestricted work activities and is able to perform the essential job functions of his or her job as set forth in the attached job description as of (date) ______________.
- ☐ Employee is medically stable to perform work activities that are compatible with his or her restrictions. Medical status will be re-evaluated on (date) __________________. This employee should be initially assigned to daily work activities that will not exceed the following restrictions/abilities:

STAND / WALK	SITTING	RIGHT ARM USE	LEFT ARM USE
☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED
☐ 7-8 HOURS	☐ 7-8 HOURS	☐ 7-8 HOURS	☐ 7-8 HOURS
☐ 5-6 HOURS	☐ 5-6 HOURS	☐ 5-6 HOURS	☐ 5-6 HOURS
☐ 3-4 HOURS	☐ 3-4 HOURS	☐ 3-4 HOURS	☐ 3-4 HOURS
☐ 1-2 HOURS	☐ 1-2 HOURS	☐ 1-2 HOURS	☐ 1-2 HOURS
☐ NONE	☐ NONE	☐ NONE	☐ NONE

OCCASIONAL LIFTING	FREQUENT LIFTING	OPERATION OF FOOT CONTROLS	OTHER RESTRICTIONS/ FUNCTIONAL ABILITIES
☐ UNLIMITED	☐ UNLIMITED	☐ UNLIMITED	☐ _______________
☐ 41-60 LB.	☐ 21-30 LB.	☐ 7-8 HOURS	☐ _______________
☐ 21-40 LB.	☐ 11-20 LB.	☐ 5-6 HOURS	☐ _______________
☐ 11-20 LB.	☐ 6-10 LB.	☐ 3-4 HOURS	☐ _______________
☐ 1-10 LB.	☐ 1-5 LB.	☐ 1-2 HOURS	
☐ NONE	☐ NONE	☐ NONE	

- ☐ Employee is medically unstable and unable to perform any work activities (even on a part-time basis) at this time. Medical status will be re-evaluated on (date) __________________.

If the employee is taking prescribed medications, can the employee safely perform the essential job functions of their position? ☐ Yes ☐ No

Does the employee have any functional restrictions based on mental conditions? ☐ Yes ☐ No

NOTE: IF YES IS INDICATED, PLEASE REFERENCE THE RETURN-TO-WORK MENTAL HEALTH FORM AS NEEDED.

Restrictions in effect until:______________ **Next appointment on:**______________
(Date) **(Date)**

Physician Contact Information:____

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______________________________ ______________________________ ______________________
Physician Signature Printed Name Date

PLEASE EMAIL THIS FORM IMMEDIATELY TO THE DEPARTMENT OF CIVIL SERVICE AND PERSONNEL:
cspersonnel@hamilton-oh.gov