THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Employee Health: Return to Work Form

Patient/Employee Name: _____ **Date of Birth:** _____

Personal Health Reason for missed work: ☐ Illness ☐ Injury ☐ Other: _____

Clearance to return to work - Without job task restrictions or limitations

Prior to returning to work, request your treating provider complete this form and securely send to Occupational Health at: **fax 913-588-2769 or occ@kumc.edu**. Your Manager and Human Resources will be notified about your return to work status. Your Manager will contact you to discuss your return to work date.

Work Status: ☐ **Return to regular work with no restrictions on** *(date)*:_____

Treating provider name (print) _____ Phone _____

Treating provider Signature _____ Date _____

Return to work with Restrictions or Limitations

Prior to returning to work, request your treating provider complete the below fields and securely send to Employee Health or delegate at: **fax 913-945-6888 or EH-ADA@kumc.edu**. Your Manager and Human Resources will be notified about your return to work status. Your Manager will contact you to discuss your return to work date.

Work Status: ☐ **OFF WORK until rechecked on** *(date)*:_____

☐ **Return to work with the physical restrictions documented below on** *(date)*:_____

Restrictions:

☐ May lift up to _____ pounds

☐ No lifting over ☐ chest ☐ shoulder ☐ head

☐ No repetitive lifting over _____ pounds

_____

☐ May push / pull up to _____ pounds
☐ with wheels ☐ without wheels

☐ No working below ☐ waist ☐ mid-thigh ☐ knee

☐ No prolonged standing or walking greater than _____ minutes per hour

☐ No prolonged sitting --- sit _____ % of time

☐ Sit down job only

☐ Alternate sitting and standing as needed

☐ No / limited use of right / left arm / hand (circle all that apply) _____

☐ Work with right / left hand / arm/ leg / foot in a brace / splint / cast (Circle all that apply)

☐ No reaching with the right / left arm (circle)

☐ Rotate job tasks to avoid repetitive hand activity

☐ No climbing stairs, ladders, ramps (circle)

☐ No kneeling or squatting

☐ No driving/operating vehicles or machinery

☐ Wound must stay clean, dry and covered

☐ Should have instruction on safe lifting, pushing, pulling

☐ On medication that may interfere with performance of critical job duties

☐ Other _____

_____

☐ Limited work schedule: _____ hours per day and/or _____ days per week or _____

☐ **Follow up appointment is required prior to removal of restrictions. Date:** _____

☐ **After restricted duty, may return to full duty with no restrictions on Date:** _____

Treating provider name (print) _____ Phone _____

Treating provider Signature _____ Date _____