

Employee Health: Return to Work Form – Personal Health Illness or Injury
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 Employee Health at fax 913-588-2769 or EmployeeHealth@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 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:

<input type="checkbox"/> May lift up to _____ pounds <input type="checkbox"/> No lifting over <input type="checkbox"/> chest <input type="checkbox"/> shoulder <input type="checkbox"/> head <input type="checkbox"/> No repetitive lifting over _____ pounds _____ <input type="checkbox"/> May push / pull up to _____ pounds <input type="checkbox"/> with wheels <input type="checkbox"/> without wheels <input type="checkbox"/> No working below <input type="checkbox"/> waist <input type="checkbox"/> mid-thigh <input type="checkbox"/> knee <input type="checkbox"/> No prolonged standing or walking greater than _____ minutes per hour <input type="checkbox"/> No prolonged sitting --- sit _____ % of time <input type="checkbox"/> Sit down job only <input type="checkbox"/> Alternate sitting and standing as needed <input type="checkbox"/> Limited work schedule: _____ hours per day and/or _____ days per week or _____	<input type="checkbox"/> No / limited use of right / left arm / hand (circle all that apply) _____ <input type="checkbox"/> Work with right / left hand / arm/ leg / foot in a brace / splint / cast (Circle all that apply) <input type="checkbox"/> No reaching with the right / left arm (circle) <input type="checkbox"/> Rotate job tasks to avoid repetitive hand activity <input type="checkbox"/> No climbing stairs, ladders, ramps (circle) <input type="checkbox"/> No kneeling or squatting <input type="checkbox"/> No driving/operating vehicles or machinery <input type="checkbox"/> Wound must stay clean, dry and covered <input type="checkbox"/> Should have instruction on safe lifting, pushing, pulling <input type="checkbox"/> On medication that may interfere with performance of critical job duties <input type="checkbox"/> Other _____ _____
--	---

 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 _____