ISSAQUAH SCHOOL DISTRICT 411

5150 220th Ave SE Issaquah, WA 98027
(425) 837-7000
www.isd411.org

Heather Tow-Yick, Superintendent

HEALTHCARE PROVIDER'S RELEASE TO RETURN TO WORK

Employee's Name:	Date:
Physician's Name:	Telephone #:

To be completed by Healthcare Provider

After reviewing the attached job description and the specific tasks within the job description, please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named Healthcare provider to return to Full Duty with NO RESTRICTIONS as of _____ (insert date).

(B) The above named employee has been released by the above named Healthcare provider to Return to Work on _____ (insert date) WITH THE FOLLOWING RESTRICTIONS through _____ (insert date).

Check applicable boxes and provide limitations/restrictions.	
☐ Lifting (Max weight) _____lbs.	☐ Walking _____hours per day
☐ Repetitive Lifting _____lbs.	☐ Standing _____hours per day
☐ Carrying _____lbs.	☐ Sitting _____hours per day
☐ Pushing/pulling _____lbs.	☐ Crawling _____hours per day
☐ Pinching/Gripping _____lbs.	☐ Kneeling _____hours per day
☐ Reaching over head	☐ Squatting _____hours per day
☐ Reaching away from body	☐ Climbing _____hours per day
☐ Repetitive Motion Restrictions:	

ISSAQUAH SCHOOL DISTRICT 411

5150 220th Ave SE Issaquah, WA 98027
(425) 837-7000
www.isd411.org

Heather Tow-Yick, Superintendent

☐ Other Restrictions:	
These limitations/restrictions are:	☐ Temporary limitations/restrictions ☐ Permanent limitations/restrictions

IF THE ABOVE RESTRICTION CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS UNDERSTOOD THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK.

My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physician's Name (Please Print):	
Physician's Signature:	Date:

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Name (Please Print):	
Employee's Signature:	Date: