PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Human Resources
P.O. Box 260005 Conway, SC 29528-6005
(843) 488-6559
Fax- 843-488-7754

Employee's Name:	Date:
Physician's Name:	Telephone No.:

To be completed by Physician

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 physician to return to Full Duty as of _____(Date) with **NO RESTRICTIONS**.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) **WITH THE FOLLOWING RESTRICTIONS** through _____(Date).

Check applicable boxes and provide limitations/restrictions.	
☐ **Lifting (Max weight in lbs) _____lbs.**	☐ **Walking _____ hours per day**
☐ **Repetitive Lifting _____lbs.**	☐ **Standing _____ hours per day**
☐ **Carrying _____lbs**	☐ **Sitting _____ hours per day**
☐ **Pushing/pulling _____lbs.**	☐ **Squatting _____ hours per day**
☐ **Reaching over head**	☐ **Kneeling _____ hours per day**
☐ **Reaching away from body**	☐ **Crawling _____ hours per day**
	☐ **Climbing _____ hours per day**
☐ **Repetitive Motion Restrictions:**	
☐ **Other Restrictions (include any appliances necessary for the employee to function at work):**	
☐ **Medication (include any medication that the employee may be on that would interfere with job performance):**	

These limitations/restrictions are:

☐ Temporary limitations/restrictions ☐ Permanent limitations/restrictions

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 Signature	Date: