Return to Work Physician Certification

To be completed by Employee's Health Care Provider and returned to Human Capital via fax to 937-499-1519 or by email to courtney.hampton@ketteringschools.org **at least three business days prior to the return to work.**

Section 1: To be completed by **Employee: *PLEASE PRINT***

Employee:_____ Title_____

Section 2: To be completed by **Health Care Provider: *PLEASE PRINT***

Name of Health Care Provider_____

Type of Practice_____

Street Address_____

City: _____ State: _____ Zip code: _____ Telephone Number: _____

Date of this exam: _____ Next Appointmentt Date: _____

Did you review a written description of the employee's job duties? **Yes or No**

2. Physical Limitations: To be completed by **Health Care Provider**

	Description		**Description**
	Allow frequent change of body position		Avoid tools that vibrate or jerk
	Avoid reaching/lifting over chest height		No work requiring awkward wrist/arm position
	Avoid climbing stairs/ladders		Avoid repetitive gripping/twisting/pinching
	Avoid kneeling/crawling		Use injured hand/arm as light assist only
	Avoid squatting (knees bent > 80 degrees)		Must accommodate splint/brace/crutches/sling
	Can lift up to : 3 5 10 15 20 lbs		No driving commercial vehicle
	Can lift up to : 25 30 35 40 50 lbs		No work at heights exceeding two feet
	May push/pull: 15 30 50 lbs of force		Avoid twisting like mopping/buffing/sweeping
	Alternate between sit/stand as tolerated or		Clerical work only
	Limit prolonged standing or walking		May work ___ hours per day
	Sit down job		May work ___ hours per week
	Keep the injured area dry and clean		Footstool R/L Foot, alternate on standing
	No use of injured hand/arm		

Turn Over for more information

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Additional Comments/Restrictions:

_____

_____

_____

I hereby certify that the above-named employee has been under my care from _____to _____ and may return to work (please circle one) **with** OR **without** physical limitations on:

Date: _____

If physical limitations are indicated above, what is the estimated date the employee can return to work without physical limitations? Date: _____.

Section 3: To be completed by **Health Care Provider:**

Physician Signature _____ Date_____

Kettering City Schools Human Capital Use Only:

Date Received_____

Reviewed by:_____ Date_____

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