

Please complete and return this notice to your patient before s/he leaves your office.



**BURBANK UNIFIED SCHOOL DISTRICT
HUMAN RESOURCE SERVICES**

1900 WEST OLIVE AVENUE • BURBANK • CALIFORNIA • 91506
TELEPHONE (818) 729-4400 • FAX (818) 729-4554

CERTIFICATE FOR RETURN TO WORK OR FURTHER TREATMENT

Patient/Employee Name: _____ Job Title: _____

Industrial Injury Yes ☐ No ☐ Date of Injury/Disabling Condition: _____ Exam Date: _____

The above employee has been under my care since _____ (Date)

PATIENT'S STATUS

Please indicate **ALL** that apply.

- ☐ Job Analysis or Job Description has been reviewed and taken into consideration.
- ☐ Return to Work with **NO RESTRICTIONS** on _____ (Date) Follow up visit (if needed) _____
- ☐ (Date) Return to Work **WITH RESTRICTIONS**** starting _____ (Date) thru _____ (Date)
- ☐ Employee is expected to **RETURN TO FULL DUTY WITHIN 60 DAYS** ☐ Restrictions are
- ☐ **PERMANENT TAKEN OFF WORK** starting _____ (Date) thru _____ (Date)
- ☐ Next Appointment Date: _____

****NOTE PHYSICAL RESTRICTIONS BELOW**

PHYSICAL ACTIVITY RESTRICTIONS

- | | |
|--|---|
| ☐ NO repetitive lifting/carrying of _____ lbs. or more | ☐ NO repetitive bending / stooping |
| ☐ NO lifting/carrying of _____ lbs. or more | ☐ NO repetitive squatting / kneeling |
| ☐ NO repetitive pushing/pulling of _____ lbs. or more | ☐ NO prolonged standing in excess of _____ hours |
| ☐ NO pushing/pulling of _____ lbs. or more | ☐ NO prolonged sitting in excess of _____ hours |
| ☐ NO at or above shoulder level reaching | ☐ Must alternate sitting/standing |
| ☐ NO repetitive keyboarding in excess of _____ minutes per hour | ☐ NO running / jumping / climbing |
| ☐ NO prolonged walking in excess of _____ hours | |
| ☐ Other: (please be specific) _____ | |

Additional Physician Restrictions:

Physician's Original Signature

Date

PLEASE PRINT:

Physician's Name: _____ CA Lic #: _____

Address _____

Phone _____ Fax: _____

RETURN FORM TO: Burbank Unified School District – Human Resources Services

05/09