LOS LUNAS SCHOOLS®
Every Student Matters. Every Moment Counts.

LOS LUNAS SCHOOLS
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Andrew Saiz

HEALTHCARE PROVIDER WORK RELEASE FORM

Employee Name:_________________________________ **Date:**____________________

Upon work release of employee, please complete the following:

1. Employee work release date: _________________________
2. Is employee able to complete job duties as per attached job description? **YES** ☐ **NO**☐

____

LIFTING:

Is employee able to lift the required physical capacity based on the job description attached?

YES ☐ Yes, employee is able to lift the required physical capacity based on the job description.

NO☐ **If no, please check the lifting restrictions:**

> 5 lbs ☐ 10 lbs ☐ 15 lbs ☐ 20 lbs ☐ 25 lbs ☐ < 50 lbs ☐

Other____

Please check the boxes below **IF WORK RESTRICTIONS APPLY** to the Physical Requirements.

WORK ACTIONS:

Finger dexterity ☐ Sitting ☐ Standing ☐ Walking ☐

REPETITIVE MOTIONS:

Hand: Right ☐ Left ☐ Both ☐

Foot: Right ☐ Left ☐ Both ☐

Grasping hand: Right ☐ Left ☐

Fine manipulation: Right ☐ Left ☐

USE OF HEAD AND NECK:

Static ☐ Flexing ☐ Rotating ☐

WORK POSITIONS:

Bending ☐	Squatting ☐	Crawling ☐
Climbing ☐	Reaching ☐	Vision ☐

BALANCE AND COORDINATION:

1. Please list any **additional work restrictions** based on your recommendation for the employee.

By signing the Healthcare Provider work release form, I verify I have reviewed the job description of the employee listed above.

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date