

1717 4th Street, Santa Monica, CA 90401, 310/450-8338

CERTIFICATE FOR RETURN TO WORK OR FURTHER TREATMENT

Name of Employee _____ Job Title _____ Date _____

Industrial Injury Yes ☐ No ☐

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

PLEASE INDICATE BELOW THE EMPLOYEE'S WORK STATUS

☐ He/she may return to **full work duties** on _____(Date) Follow up visit (if needed) _____(Date)

☐ He/she is **Temporarily Totally Disabled** from _____(Date) to _____(Date)

☐ He/she may **return to work modified to accommodate the following restrictions** on _____ (Date)

☐ Restrictions are **TEMPORARY** through _____ (date)☐ Restrictions are **PERMANENT**

Check all physical activity restrictions.

☐ NO **repetitive lifting/carrying** of _____ lbs. or more☐ NO **lifting/carrying** of _____ lbs. or more☐ NO **repetitive pushing/pulling** of _____ lbs. or more

☐ NO **pushing/pulling** of _____ lbs. or more

☐ NO reaching at (or above) shoulder level☐ NO repetitive keyboarding in excess of ____min. per hour

☐ NO **prolonged walking** in excess of _____ minutes

☐ **Other** (please be specific)☐ NO repetitive bending/stooping > _____times/hour☐ NO repetitive squatting/kneeling > _____times/hour☐ NO **prolonged standing** in excess of _____ minutes☐ NO **prolonged sitting** in excess of _____ minutes☐ Must **alternate sitting/standing** every _____ minutes☐ NO **running / jumping / climbing** (circle your answer)

ADDITIONAL CLARIFICATION/ RESTRICTIONS

Doctor's Signature

License Number

Expiration Date

PLEASE PRINT:

Doctor' s Name_____

Address _____

Phone _____

A decorative horizontal border consisting of a repeating pattern of diamond shapes.

For HR Use Only

Assistant Superintendent of HR or designee

Date