Return form to:
Human Resources Department
501 Mustang
Denver City, Texas 79323
Ph:806-592- 5900

Denver City Independent School District
Return to Work Certification

Date: _____

Name of worker	Position/School Name

Please complete the following information and return with the injured employee.

1. Is the worker medically stationary? ☐ Yes ☐ No Date _____ Next scheduled appointment date _____
2. Worker is released to:
   - ☐ full duty without limitations Date _____ (Do not complete lines 3 through 11. Sign below.)
   - ☐ modified duty from (date) _____ through (date) _____ (specify limitations below.)
   - ☐ modified hours — specify _____ from (date) _____ through (date) _____

	Hours: No limitations	1	2	3	4	5	6	7	8
3. In a 7 hour workday, worker can stand/walk a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. At one time, worker can stand/walk	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. In an eight-hour workday, worker can sit a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. At one time, worker can sit	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	<10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:

	Right	Left
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No

Dominant hand ☐ Right ☐ Left

9. Worker can use feet for repetitive raising and pushing (: ☐ Yes ☐ No

10. Worker is able to:

	Continuous 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Climb	☐	☐	☐	☐	☐
g. Balance	☐	☐	☐	☐	☐
h. Reach	☐	☐	☐	☐	☐
i. Push/pull	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of physician	Physician's typed name	Date

For Office Use Only:
Approved: _____
Not Approved: _____
Signature: _____ Date: _____