

RELEASE TO RETURN TO WORK FOR WORKERS' COMPENSATION

Risk Management Department • Lincoln Public Schools

Phone: 402-436-1760
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**TO BE COMPLETED BY TREATING PHYSICIAN AT EACH APPOINTMENT
PROVIDE COPY TO YOUR SUPERVISOR AND RISK MANAGEMENT**

Name: _____ Date of Injury: _____ Date of Visit: _____

Diagnosis: _____

Studies Reviewed: _____

Additional Comments: _____

Next Appointment

Day: _____ Date: _____ Time: _____ ☐ AM ☐ PM Location: _____

☐ RETURN TO WORK WITH NO RESTRICTIONS

☐ Sedentary Work

Lifting 10 lbs. maximum and occasionally lifting and/or carrying small items

☐ Light Work

Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.

☐ Light Medium Work

Lifting 30 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 20 lbs.

☐ Medium Work

Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.

☐ Light Heavy Work

Lifting 75 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs.

☐ Heavy Work

Lifting 100 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 50 lbs.

☐ No Work

☐ Maximum Medical Improvement Date/Release From Medical Care: _____

1. In a 8 hour work day patient may:

a. Stand/Walk

☐ None ☐ 4-6 hrs ☐ >8
☐ 1-4 hrs ☐ 6-8 hrs

b. Sit

☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ >8

c. Drive

☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ >8

2. Patient may use R/L hand(s) for repetitive:

☐ Single grasping ☐ Pushing & pulling
☐ Fine Manipulation

3. Patient may use R/L foot/feet for repetitive movement.

☐ Yes ☐ No

4. Patient is able to:

Bend	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Squat	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Climb	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Twist	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently
Reach	<input type="checkbox"/> never	<input type="checkbox"/> occasionally	<input type="checkbox"/> frequently

☐ Other _____

These restrictions are in effect until _____ Restrictions of "as tolerated" are NOT acceptable

Therapy Prescription ☐ PT ☐ OT ☐ ST _____ times per week _____ weeks/or _____ number of visits

☐ Evaluate and Treat _____

Medications prescribed ☐ Yes ☐ No

Diagnostic tests ordered _____

Physician Signature: _____ Date: _____

I received a copy of this form and understand any restrictions apply to both **home, work, sports, hobbies, recreation, etc.**

I hereby authorize treatment and the disclosure of this document to my employer and/or to agents of my employer by my signature below.

Employee Signature: _____ Date: _____