RM0005
Rev. 7/17

RELEASE TO RETURN TO WORK FOR WORKERS' COMPENSATION

Risk Management Department
Lincoln Public Schools

Phone: 402-436-1760
Fax: 402-458-3276

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 ❒ never ❒ occasionally ❒ frequently
   Squat ❒ never ❒ occasionally ❒ frequently
   Climb ❒ never ❒ occasionally ❒ frequently
   Twist ❒ never ❒ occasionally ❒ frequently
   Reach ❒ never ❒ occasionally ❒ frequently

❒ **Other** _____

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

Therapy Prescription ❒ PT ❒ OT ❒ ST _____ times per week times _____ 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: _____

To comply with the Genetic Information Nondiscrimination Act of 2008, we are asking that you not provide any genetic information when completing this form.