RM0036
Rev. 7/18

Phone: 402-436-1767
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RELEASE TO RETURN TO WORK

Human Resources Department
Lincoln Public Schools

(Use Black or Blue Ink)

Lincoln Public Schools employees who have surgery, have an accident resulting in injury and/or treatment by a medical provider, have a major health issue such as heart attack; stroke; loss of consciousness; disease; removed from the building by emergency personnel, etc., need to have this form completed by the treating physician prior to returning to work. **If the form notes restrictions, the form must be in the Human Resources office at LPSDO with sufficient work days to schedule Health Care Response Team meeting if necessary. Forms releasing the employee to full duty with no restriction need to be in Human Resources by the day of release.**

TO BE COMPLETED BY EMPLOYEE:

Name and ID#: _____ Supervisor's Name: _____

Position: _____ Building Name: _____

Date of surgery/incident: _____ Absence Date(s): _____

Type of surgery/treatment/diagnosis: _____

TO BE COMPLETED BY PHYSICIAN:

Employee is released to full duty **with no limitations/restrictions** on (provide date): _____

OR

Employee is released to **modified duty with the following restrictions**: (check all that apply)

Note: As tolerated or similar language is not acceptable. Restrictions are in place beginning and ending as noted. End date can be next appointment date but the beginning and end dates must be supplied.

Restrictions begin (date): _____ (required field) Restrictions end (date): _____ (required field)

Other Specific Restrictions: _____

_____

Patient is able to:

	33% or less of day	34-64% of day	65% or greater of day
Bend:	❑ Occasional	❑ Frequent	❑ Constant
Squat:	❑ Occasional	❑ Frequent	❑ Constant
Climb Stairs:	❑ Occasional	❑ Frequent	❑ Constant
Climb Ladders:	❑ Occasional	❑ Frequent	❑ Constant
Twist at Trunk:	❑ Occasional	❑ Frequent	❑ Constant
Reach Overhead:	❑ Occasional	❑ Frequent	❑ Constant
Kneel:	❑ Occasional	❑ Frequent	❑ Constant

Maximum Lift/Carry Weight: _____

In an 8-hour day, patient may:

Stand/Walk: ❑ None ❑ 1-3 hours ❑ 3-5 hours ❑ 5-8 hours
Sit: ❑ 1-3 hours ❑ 3-5 hours ❑ 5-8 hours
Drive: ❑ 1-3 hours ❑ 3-5 hours ❑ 5-8 hours

May use hands for repetitive activity:

Simple Grasping: ❑ Yes ❑ No
Pushing/Pulling: ❑ Yes ❑ No
Fine Manipulation: ❑ Yes ❑ No

May use foot/feet to operate controls: ❑ Yes ❑ No

Other Specific Restrictions: _____

_____

Physician Signature: _____

Physician Typed/Printed Name: _____ Date: _____

HUMAN RESOURCES USE ONLY:

Date reviewed and approved for return to work: _____

Name of Supervisor notified: _____

Signature of Human Resources Supervisor approving return to work: _____

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