Workers Compensation Return to Work Form

Michigan Technological University

1400 Townsend Drive, Houghton MI 49931

Employee Name: _____ and date of injury/illness: _____/_____/_____.

Examination/treatment date: ____/____/____.

Brief diagnosis of injury: (Indicate clinical manifestation of condition to what body part or surface).

_____

_____

_____

Patient Has Been Advised of the Following Regarding Return to Work:

1. _____ **Return to work immediately** with **NO** restrictions.

2. _____ **Medication has been prescribed**. Please indicate any restrictions on the employee's work activities as a result of medication.

3. _____ **No return to work until** (date) ____/____/____ (no work until this date and no medical restrictions after this date).

4. _____ **Return to work with temporary restrictions** beginning (date) ____/____/____ and ending (date) ____/____/____.
   Next scheduled examination/treatment (date) ____/____/____. Please indicate restrictions below:

Number of Consecutive Hours Patient Can Perform Specified Activity During an 8-hour Work Period

Number of Hours	6-8	4-5	1-3	0
Sitting				
Standing				
Walking				
Pushing				
Pulling				
Climbing				
Bending				
Kneeling				
Reaching				
Grasping				

Weight Handling Frequencies

Number of Times Per Hour	15 or More	10-15	1-10	0
Lifting & Carrying				
a. Less than 10 pounds				
b. 10-20 pounds				
c. 20-50 pounds				
d. 50-100 pounds				

Number of constructive hours patient can perform the above weight handling frequencies during an 8-hour work period?_____

Indicate any additional restrictions:_____

_____

_____

Attending Physician's Signature:_____
Print Name:_____
Address: _____

Employee: Completed form to be returned to supervisor following each examination. Supervisor: When received, route this form immediately to Environmental Health and Safety (EHS).

WC-3/00