|  |  |  |  |
| --- | --- | --- | --- |
| Personal Details | | | |
| Last Name: |  | First Name: |  |
| Injury/Illnesses Date: |  | DoB: |  |
| Job Title: |  | | |
| Work Location: |  | Phone: |  |
| Supervisor: |  | HR Partner: |  |

|  |  |  |
| --- | --- | --- |
| Return to Work Assessment and Report (Completed by Physician) | | |
|  | Health Care Professional understands the role expectations / essential duties | |
|  | Fit (Full Duty) – no restrictions or accommodation required | Start (mm/dd/yyyy): |
|  | Fit subject to work modifications | Start (mm/dd/yyyy): |
|  | Unable to meet inherent requirements of the role | Start (mm/dd/yyyy):       End: |
|  | Accommodations required *(explain)*: | Start (mm/dd/yyyy): |
|  | Medication impairs ability to function on the job | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Activity Restrictions | | | | | | | |
| **Posture Restrictions** | Max Hours Per Day  0 2 4 6 8 | | Other | **Motion Restrictions** | Max Hours Per Day  0 2 4 6 8 | Other | **Misc. Restrictions *(if any)*** |
| Standing |  | |  | Walking |  |  | Max hours per day of work |
| Sitting |  | |  | Climbing *(stairs/ladders)* |  |  | Sit/Stretch breaks of       per |
| Kneeling/Squatting |  | |  | Grasping/Squeezing |  |  | Must wear splint/cast at work |
| Bending/Stooping |  | |  | Wrist *(flexion/extension)* |  |  | Must use crutches at all times |
| Pushing/Pulling |  | |  | Reaching |  |  | No driving/operating heavy equipment |
| Twisting |  | |  | Overhead Reaching |  |  | Can only drive automatic transmission |
| Other |  | |  | Keyboarding |  |  | Must keep        elevated  clean & dry |
|  | | | | Other |  |  | No skin contact with |
| **Restrictions Specific to *(if applicable)*** | | | | **Lift/Carry Restrictions *(if any)*** | | | Dressing changes necessary at work |
| Left Hand / Wrist | | Left Leg | | May not lift/carry objects more than       lbs  For more than       hours per day | | | No Running |
| Right Hand / Wrist | | Right Leg | | No work /       hours/day work:  in extreme hot/cold environments  at heights or on scaffolding |
| Left Arm | | Back | | May not perform any lifting/carrying | | |
| Right Arm | | Left Foot / Ankle | | Other: | | | **Medication Restrictions** |
| Neck | | Right Foot / Ankle | | Must take prescription medication(s) |
| Other Restrictions (if any) | | | | Advised to take over-the-counter meds |
| Medication may make drowsy   *(possible safety/driving issues)* |
| These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. **Note:** These restrictions should be followed outside of work as well as at work. | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Next Steps |  | |
| Next Reassessment date (mm/dd/yyyy): |  | |
| Treating Physician Name: |  | Phone: |
| Treating Physician Signature: |  | |
| Certification Date (mm/dd/yyyy): |  | |

|  |  |
| --- | --- |
| **Prior to Return to Work**  Notify your Case Coordinator or Medical Case Manager.  Forward a copy of this form via email or fax to: | US: Houston Health Services Exploration: Houston Health Services  AU: Health Specialist Projects: Houston Health Services  TTPU: Health Specialist Legacy Assets: Houston Health Services  Mexico: Houston Health Services |