|  |
| --- |
| 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 ServicesTTPU: Health Specialist Legacy Assets: Houston Health ServicesMexico: Houston Health Services  |