ATTENDING PHYSICIAN STATEMENT
RETURN TO WORK FORM
GEAUGA COUNTY COMMISSIONERS

12611 Ravenwood Drive Suite #350
Phone: 440-279-1670, Fax: 440-279-1317

Patient Name	Date
Date of Injury If applicable, BWC Risk #: 32800001	Time In Time Out
DIAGNOSIS:	_____ Initial Visit _____ Follow-up

Summary of Findings

Return to work with no limitations	Date:	Next scheduled work shift
Return to work with limitations	From:	To:
Totally Disabled for Work	From:	To:

Work Limitations In an 8 Hour Work Day

Patient Can Lift/Carry	Cannot Do At All	Can do Occasionally 1%-33%	Can do Frequently 34%-66%	Can do Continuously 67%-100%
Up to 10 pounds	_____	_____	_____	_____
11-20 pounds	_____	_____	_____	_____
21-50 pounds	_____	_____	_____	_____
51-100 pounds	_____	_____	_____	_____
LIMIT THE FOLLOWING ACTIVITIES				
Bend	_____	_____	_____	_____
Twist/Turn	_____	_____	_____	_____
Reach below knee	_____	_____	_____	_____
Push/Pull Wt. _____#	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____
Squat/Kneel	_____	_____	_____	_____
Stand or Walk	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Drive company vehicle	_____	_____	_____	_
LIMIT THE FOLLOWING HAND ACTIVITIES: PLEASE CIRCLE - RIGHT LEFT BOTH				
Operate power or	_____	_____	_____	_____
vibrating tools	_____	_____	_____	_____
Torquing, crimping	_____	_____	_____	_____
Repetitive wrist motion	_____	_____	_____	_____

ADDITIONAL COMMENTS

Additional Limitations

___Change positions every:___ half hour or _____ hours
___ Patient must wear splint/bandage during work activities
___ Keep wound clean and dry.
___ Patient may not use: ___ Right arm/hand ___ Left arm/hand
____ Unable to perform duties requiring depth perception or using high speed machinery
____ May/may not wear rubber/cotton/leather glvs
____ No unguarded machinery or work in which dressing/appliance a safety hazard
____ Avoid: ___ fumes ___ irritants ___ chemical aerosols/
Contact: ___ heat ___ cold ____
No incentive oriented duties
____ Medication prescribed: ____ May be taken at work ____ May not be taken at work

Physician Signature **Physician Name** **Date**

Patient Referred to Physical Therapy:
Referred to:_____
Address & Phone: _____
_____
Appointment Date/Time: _____

Patient Referred to a Specialist:
Referred to: _____
Address & Phone: _____
_____
Appointment Date/Time: _____

TREATMENT PLAN **Next Appointment Date:** **Time:**

G For your reference, a job description is attached.

HEALTH CARE PROVIDER INFORMATION

Attached to this *Health Care Provider Information* form is the current description of the essential functions of the position occupied by _____(employee name), including the physical and mental demands of the job. Please answer the following questions regarding the employee=s condition as it relates to the essential functions and possible accommodations.

G What is _____medical condition?

G How long has he/she had this condition?

G Is the condition temporary or permanent?

G How is this condition being treated? If medication is provided, what is the effect of the medication on the employee and does the medication control the effects of the condition?

G Does the condition affect the employee=s ability to perform any of the essential function of the position?
For your reference, a copy of the position description is being provided.
If yes, please describe how the condition affects the person=s ability to perform his/her specific job functions.

G What, if any, restrictions have you placed on the employee?

G Do any of these restrictions preclude the employee from performing the essential functions of his/her job?

Continued on Reverse

G Does the employee experience any limitations in any major life activities such as walking, talking, seeing, speaking, working, caring for oneself, breathing, etc.?

G In your opinion, what are some ways in which the employer might be able to allow the employee to perform all of the essential functions of his/her job?

G Is the need for accommodation likely to be temporary or permanent? If temporary, how long do you estimate the need for accommodation will exist?

_____	_____
Provider Name (please print)	Professional License or Specialty
_____	_____
Signature	Date

For those under the Hiring Authority of the Commissioners

With employee authorization, the Health Care Provider may return this form directly to:

Kathleen K. Hostutler
Human Resources Administrator
Geauga County Commissioners
12611 Ravenwood Drive, Suite #350
Chardon, OH 44024

Direct Fax: 440-279-1317
E-Mail: khostutler@co.geauga.oh.us

ATTACHMENTS:
G Attending Physician Statement
G Job Description
G Job Analysis – if available