



**PHYSICIAN'S RETURN TO WORK
RECOMMENDATION FORM**

THIS FORM IS TO BE COMPLETED BY THE PHYSICIAN ATTENDING THE INJURED OR DISABLED WORKER AND FAXED TO THE MANAGER, HUMAN RESOURCES/HEALTH AND SAFETY, SD 63 (SAANICH), AT 250-652-7372

This form will be used to provide our employee with work suitable to his/her physical abilities and/or limitations. The employee recognizes that this information may be released to any third party who has interest in assessing their medical fitness to return to work and/or entitlement to benefits.

Employee's Name: _____ **Occupation:** _____

Details of Physical Limitations

Walking: Some Restrictions No Restrictions No Walking
 Up to 1 hour
 Up to 3 hours **Comments:** _____
 Up to 6 hours

Standing: Some Restrictions No Restrictions No Standing
 Up to 1 hour
 Up to 3 hours **Comments:** _____
 Up to 6 hours

Sitting: Some Restrictions No Restrictions No Sedentary
 Up to 1 hour
 Up to 3 hours **Comments:** _____
 Up to 6 hours

Climbing: Some Restrictions No Restrictions No Climbing
(stairs/ (no. of stairs or times
ladders) per shift) **Comments:** _____

Carrying/ Lifting/ Push/ Pull: Some Restrictions No Restrictions No Carrying/Lifting/Pushing/Pulling
 Up to 5 lbs
 Up to 10 lbs **Comments:** _____
 Up to 20 lbs

Bending: Some Restrictions No Restrictions No Bending
Limit to _____ bends **Comments:** _____
per. _____

Sweeping/ Mopping: Some Restrictions No Restrictions No Sweeping/Mopping
 No Side to Side **Comments:** _____

Shoulder Movements: Some Restrictions **Comments:** _____
 No Restrictions
 No Above Shoulder
 No Below Waist
 No Arm Extension
 No Shoulder Movement

If suitable employment is available which meets the above-defined restrictions, is this worker capable of returning to work? Yes No

Modified duties can start on: _____ for 4 6 8 hours per day (please circle one).

Anticipated date of return to full duties: _____

Physician's Name: _____

Physician's Signature: _____

Date: _____

Clinic / Physician Stamp