**RETURN TO WORK/SCHOOL**

Date Examined: **[DATE]**

Patient Name: **[NAME]**

[ ]  Full Duty: Return to work/school with no restrictions.

[ ]  Light Duty: Return with restrictions described below.

[ ]  Off Work: The patient is not able to return to work/school until **[DATE]**

|  |  |  |
| --- | --- | --- |
| **Restrictions:** |  | **Diagnosis:** |
| [ ]  No bending  |  |  |
| [ ]  No twisting |  |  |
| [ ]  No lifting more **[#]** than lbs. |  |  |
| [ ]  No climbing |  |  |
| [ ]  Other |  |  |
|  |  |  |
| **Limitations:** |  |  |
| [ ]  Work limited hours per day **[#]** (hours) |  |  |
| [ ]  Several breaks throughout the day |  |  |
| [ ]  Must wear brace |  |  |
| [ ]  Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Signature**  |  | **Date** |