**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** |