



Return to work Medical Evaluation Form Procedures 12-29-06

These procedures outline the immediate use of our new Return to Work Medical Evaluation Form. This form is to be utilized whenever an employee is absent from work, for illness or injury, for 3 days or more. The purpose of this procedure is to safely return the injured or ill employee to his or her full working capacity. All employees must adhere to the following:

1. All leave request procedures must be followed.
2. Prior to returning to work, the employee must have his or her health care provider or physician complete and sign the Return to Work Medical Evaluation Form (available on the L:/Drive and SAHA-Net.)
3. This form will inform SAHA of the patient's return to work status to include any restrictions or limitations.
4. Upon completion of the form it must be returned to the Human Resources office which will then release the employee to return to work and report to his or her supervisor.
5. Provisional, part time and full time employees will adhere to this process.
If an employee anticipates an injury or illness to cause him or her to miss work for an extended period, the employee should visit SAHA's Human Resources office to discuss eligibility, documentation and procedures for FMLA and /or Short-Term Disability.



Return to Work Medical Evaluation Form

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient. Our goal is to return the injured or ill SAHA employee to his or her full working capacity as soon as possible. Thank you for your assistance.

Please print

Employee's Name: _____ SS#: _____

Date of injury/surgery/onset of illness: _____ Date of exam: _____

Diagnosis or description of injury/surgery/illness: _____

The patient's return to work status is:

☐ Return to regular work

Date: _____

☐ Able to return to work with noted restrictions

Date: _____

☐ Unable to return to work until next evaluation

Date: _____

☐ Referred to another health care provider

Name: _____

Date: _____

Lifting restrictions

☐ None

☐ 40-50 lbs.

☐ 30-39 lbs.

☐ 20-29 lbs.

☐ 10-19 lbs.

☐ less than 10 lbs.

The patient's restrictions or limitations are:

☐ Lifting above shoulders

☐ Lifting from below knees

☐ Twisting of upper body

☐ Climbing

☐ Squatting, kneeling or crawling

☐ Repetitive wrist movement

☐ Repetitive feet movement

☐ Operating industrial equipment

☐ Driving company vehicle or tractor/trailer

☐ Exposure to dust or fumes

☐ Exposure to skin irritants, solvents

☐ Must wear hearing protection

☐ Must wear eye protection

☐ Alternate sitting and standing every ____ hours

☐ Limit standing to ____ hours a day

☐ Limit daily work to ____ hours a day

☐ Under medication that could affect ability to work

Please explain: _____

The patient can perform them:

Frequently

Occasionally

Not at all

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Follow-up plan of treatment ☐ None ☐ Return visit on _____ at _____ a.m./p.m.

Additional comments: _____

Health care provider's signature _____

Health care provider's name (please print) _____

Date signed _____

Phone number (include area code) _____

Street address _____

City, State and Zip code _____