CERTIFICATE FOR RETURN TO WORK OR FURTHER TREATMENT

Patient/Employee Name: _____ Job Title: _____

Industrial Injury: Yes ☐ No ☐ Date of Injury/Disabling Condition: _____ Exam Date: _____

The above employee has been under my care since _____ (Date) .

☐ I have read the employee's job description

PATIENT'S STATUS

Please indicate **ALL** that apply.

☐ Job Analysis or Job Description has been reviewed and taken into consideration.
☐ Return to Work with **NO RESTRICTIONS** on _____ (Date)
Follow up visit (if needed) _____ (Date)
☐ Return to Work **WITH RESTRICTIONS**** starting _____ (Date) thru _____ (Date)
☐ Employee is expected to **RETURN TO FULL DUTY WITHIN 60 DAYS**
☐ Restrictions are **PERMANENT**
☐ **TAKEN OFF WORK** thru _____ (Date)
☐ Next Appointment Date: _____ (Date)

**NOTE PHYSICAL RESTRICTIONS BELOW

PHYSICAL ACTIVITY RESTRICTIONS

☐ NO repetitive lifting/carrying of _____lbs. or more
☐ NO lifting/carrying of _____lbs. or more
☐ NO repetitive pushing/pulling of _____lbs. or more
☐ NO prolonged standing in excess of ____hours
☐ NO pushing/pulling of _____ lbs. or more
☐ NO at or above shoulder level reaching
☐ NO repetitive keyboarding in excess of ____minutes per hour
☐ NO prolonged walking in excess of ____hours
☐ NO repetitive bending / stooping
☐ NO repetitive squatting / kneeling
☐ NO prolonged sitting in excess of ____hours
☐ Must alternate sitting/standing
☐ NO running / jumping / climbing
☐ Other: (please be specific) _____

☐ **ADDITIONAL COMMENTS / RESTRICTIONS:**

☐ **I RECOMMEND THE FOLLOWING MODIFICATIONS/ ACCOMMODATIONS:**

_____ _____
Physician's Original Signature Date

PLEASE PRINT:

Physician's Name: _____ CA Lic #: _____

Address _____

Phone _____ Fax: _____

PLEASE RETURN FORM TO: **Las Virgenes Unified School District**
Fax # 818-878-5292