



Employee's Name: _____ Date: _____

Physician's Name: _____ Telephone #: _____

To be completed by Physician:

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) or (C) as appropriate and sign and date below:

(A) The above named employee has been released by the above named physician to return to full duty as of _____ (Date) **WITH NO RESTRICTIONS.**

(B) The above named employee has been released by the above named physician to return to work on _____ (Date) **WITH THE FOLLOWING RESTRICTIONS** through _____ (Date - unknown will not be accepted).

(C) The above named employee has **NOT** been released by the above named physician to return to work at this time. Follow up appointment is scheduled for _____ (Date - unknown will not be accepted).

Check applicable boxes and provide limitations/restrictions:

- | | |
|---|--|
| <input type="checkbox"/> Lifting (Max weight in lbs) _____ lbs. | <input type="checkbox"/> Walking _____ hours per day |
| <input type="checkbox"/> Repetitive Lifting _____ lbs. | <input type="checkbox"/> Standing _____ hours per day |
| <input type="checkbox"/> Carrying _____ lbs. | <input type="checkbox"/> Sitting _____ hours per day |
| <input type="checkbox"/> Pushing/Pulling _____ lbs. | <input type="checkbox"/> Crawling _____ hours per day |
| <input type="checkbox"/> Pinching/Gripping _____ lbs. | <input type="checkbox"/> Kneeling _____ hours per day |
| <input type="checkbox"/> Reaching over head | <input type="checkbox"/> Squatting _____ hours per day |
| <input type="checkbox"/> Reaching away from body | <input type="checkbox"/> Climbing _____ hours per day |

Repetitive Motion Restrictions:

Other Restrictions:

These limitations/restrictions are: Temporary limitations/restrictions expected to last until _____ (Date)
 Permanent limitations/restrictions

If you have questions or need additional information regarding the employee's essential job functions, please contact the Workers' Compensation Coordinator at (781) 431-1019 x2236.

My signature indicates that I have **read and understand** the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physician's Name (Please Print): _____

Physician's Signature: _____ Date: _____

I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature: _____ Date: _____