

FMLA RETURN TO WORK AUTHORIZATION FORM

Name of Physician: _____ Name of Employee: _____

Instructions: Physician complete in full.

1. Medical Diagnosis: _____

2a. In an 8 hour workday, how many hours can this employee: (please check appropriate boxes)

Sit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Stand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Walk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests

2b. In a given day, for how many hours can this employee sit, stand, and/or walk in combination?

2 4 6 8 10 12 14 16 Greater than 16

3a. Other Capabilities: (please check appropriate boxes)

	Never	Occasionally	Frequently	Continuously
Lift				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3b. Upper Extremities:

Which hand is dominant? Right Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing and Pulling	Fine Manipulation
Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



3c. Lower Extremities:

Use of feet/legs for repetitive movement as in operation of foot controls and motor vehicles:

Right Extremity	Left Extremity	Simultaneously
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Work Environment Restrictions:

Can this employee:

Be exposed to marked changes in temperature and humidity? Yes No

Be exposed to unprotected heights? Yes No

Be around moving machinery? Yes No

5. Other Restrictions, please explain: _____

6. Based on your examinations(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with this employee returning to work? No Yes, please explain: _____

7. Patient may return to work: With restrictions on _____ (date).

: Without restrictions on _____ (date).

8. When, in your estimation, will this employee no longer be subject to restrictions _____ (date).

Physician's Signature	Telephone Number	Date