PLUMAS
UNIFIED SCHOOL DISTRICT

1446 East Main Street
Quincy, CA 95971
PH: 530.283.6500 x5223/ FAX: 530.283.3776

Plumas County
Office of Education

Return to Work Authorization

NOTICE TO EMPLOYEE: **Take this form to the doctor; He/She will fill out the bottom portion**

Medical Treatment is authorized with _____

Employee Name: _____ Date of Injury: _____

Brief Description of Accident/Illness: _____

Employer Name: Plumas Co. Office of Ed./PUSD Date: _____

Employer Signature _____ Title: _____

PHYSICIAN'S REPORT **MEDICAL PROVIDER: FAX COMPLETED FORM TO (530)283-3776**

Diagnosis: _____

Work Status

☐ First Aid Case / May return to regular work duties **now without restriction**

Capabilities: (No Comment Will Mean No Restrictions)

Definitions of Capabilities: Frequently = 66% of work day, Occasionally = 33% work day, Not O.K. = None

CAPABILITIES	Frequently	Occasionally	None	LIFTING	Frequently	Occasionally	None
Bend				0 to 10 lbs			
Squat				11 to 20 lbs			
Crawl				21 to 35 lbs			
Kneel				36 to 50 lbs			
Twist				51 to 75 lbs			
Overhead Reach				Carry: Max O.K. _____			
Use stairs/steps/step-stools/ladders				Use arms/repeated pushing/pulling **L/R**			
Walk on rough/uneven surfaces				Use arms/repeated grasp/lift/carry **L/R**			
Sit more than _____ hrs/min				Use hand/repeated fine manipulation **L/R**			
Operate vehicles or moving equip.				Other _____			

Restrictions observed until: _____ May return to work (date): _____

Discharge Status

☐ Follow-up appointment required ☐ Next appointment date: _____

☐ Released from care: ☐ No restrictions, no need for future medical

☐ Discharged as Permanent & Stationary w/ restrictions and/or need for future medical

☐ Non-Industrial ☐ Industrial

Physician Name **Signature** **Date**

cc: HR_____ cc: Terry Oestreich _____ Employee Benefits Tech_____ cc: Employee's Supervisor _____