

COLUMBIA SCHOOL DISTRICT #400

755 Maple St.
Burbank, WA 99323
509-547-2136

RETURN TO WORK STATUS REPORT

TO BE COMPLETED BY PHYSICIAN

FOR: _____
(Employee Name)

HAVE THE MEDICAL PROVIDER COMPLETE THIS FORM. ***DO NOT LEAVE AT THE PROVIDER'S OFFICE.*** RETURN THE COMPLETED FORM TO YOUR EMPLOYER WITHIN 24 HOURS OF YOUR VISIT AND FAX A COPY TO ESD 112 THE SAME DAY AT 360-750-9836.

Released to regular work **no restrictions** on _____ (date)

Released to work **with restrictions** on _____ (date) _____ hours per day, _____ days per week.

Sit for _____ (hrs) _____ (min) at a time. OR Sit for _____ (hrs) _____ (min) in a day.
Stand for _____ (hrs) _____ (min) at a time. OR Stand for _____ (hrs) _____ (min) in a day.
Walk for _____ (hrs) _____ (min) at a time. OR Walk for _____ (hrs) _____ (min) in a day.

Lift/carry a maximum of _____ pounds below shoulder height.

Lift/carry a maximum of _____ pounds at/above shoulder height.

Frequency of Physical Demands:

NP = NOT PRESENT - does not exist

F = FREQUENTLY - from 1/3 to 2/3 of the time

O = OCCASIONALLY - up to 1/3 of the time

C = CONSTANTLY - 2/3 or more of the time

Bend/Stoop:		<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Crouch:		<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Push/Pull:	Above shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
	At shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
	Below shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Reach:	Above shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
	At shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
	Below shoulder height	<input type="checkbox"/> Constantly	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never

Use RIGHT arm for repetitive movements (elbow and shoulder): Can Cannot

Use RIGHT hand and fingers for repetitive movements (wrist and fingers): Can Cannot

Use LEFT arm for repetitive movements (elbow and shoulder): Can Cannot

Use LEFT hand and fingers for repetitive movements (wrist and fingers): Can Cannot

Other physical/functional restrictions:

These restrictions are in effect from _____ (date) to _____ (date).

Estimated date employee can return to regular duty work: _____ (date).

(Physician's Printed Name)

(Signature)

(Date)

Follow up appointment is scheduled for: _____ (date) at _____ (time).

Clinic name & address _____ Telephone # _____