INJURY, EXPOSURE & ILLNESS RETURN TO WORK FORM

Date: _____

Employee Name:_____ Date of Injury/Exposure/Illness:_____

Physician Names:_____ Phone No. _____

Medical Diagnosis: _____

Treatment Plan: _____

Nature of Injury: ☐ New Injury ☐ No Injury/Illness Found ☐ Recurrence/Aggravation of Existing Condition

☐ Occupational ☐ Non-Occupational

Body Part Injured: _____ Dominant Hand: (check one) ☐ Right ☐ Left

Return to Work Recommendations: ☐ No Work until (date) _____

☐ Accommodated Work until (date) _____

☐ Regular Work (No accommodation required)

Accommodations: (circle) ***Frequency: (Check one definition below)**

Lifting:	0 10 20 50 lbs.	☐ Occasionally	☐ Frequently	☐ Continuously
Pushing/Pulling	0 10 20 50 lbs.	☐ Occasionally	☐ Frequently	☐ Continuously
Gripping/Pinching:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Repetitive Foot Motion:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Employee May:				
Bend:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Squat:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Climb:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Twist:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously
Stoop:	☐ None or	☐ Occasionally	☐ Frequently	☐ Continuously

No reaching above shoulders: ☐

No reaching below knees: ☐

May sit continuously: _____ hours per day

May stand continuously: _____ hours per day

Specify tool usage recommendations: _____

Above recommendations are effective beginning: _____ and are:

☐ **Temporary, effective until: _____ (next physician appointment - date, time)**

☐ **Permanent**

Physician signature: _____ Date: _____

* Frequency Definition:	**Occasionally**	**Frequently**	**Continuously**
times per hour	2	30	> 30
times per shift	< 100	100 - 500	> 500
% shift	< 33%	>33% to < 66%	> 66%

06-01-2012 **Form 2-82** **Need 4 Copies: (Doctor / Human Resources (Risk Management) / Department/ Employee)**