BONNER COUNTY
WORKERS COMPENSATION
RETURN TO WORK & FITNESS FOR DUTY FORM

THIS FORM MUST BE RETURNED TO RISK MANAGEMENT!!!
FAX: 208-265-1457
1500 Hwy 2, Suite 337,
Sandpoint, ID 83864

EMPLOYEE: _____ **INJURY DATE:** _____
EMPLOYEE'S JOB TITLE: _____ **DEPARTMENT:** _____
DATE OF EXAM: _____ **DATE OF NEXT EXAM:** _____
WORKERS COMP CLAIM #: _____

The above-named employee is under my care. I release him/her to return to work as specified below:

❑ **FULL DUTY,** usual job, no restrictions, as of: _____ (date.)

❑ **Transitional Work -** with the **following Work Restrictions/Capacities,** as of _____ (date), to be adhered to at work **until their next appointment on** _____ (date).

_____Work FULL-TIME; _____Work PART-TIME only: _____hours per day, _____ days per week

Employee can safely perform these functions: (*please check below*)

Lift /Carry	No restriction	Up to 5 lbs.	10 lbs.	25 lbs.	50 lbs.	Not at all
Push /Pull	No restriction	Up to 5 lbs.	10 lbs.	25 lbs.	50 lbs.	Not at all
Stand/Walk			No restriction	Frequently	Occasionally	Not at all
Stoop/Bend at Waist			No restriction	Frequently	Occasionally	Not at all
Kneel/Squat			No restriction	Frequently	Occasionally	Not at all
Climb			No restriction	Frequently	Occasionally	Not at all
Sit			No restriction	Frequently	Occasionally	Not at all
Other			No restriction	Frequently	Occasionally	Not at all
Reach Above Shoulder with Left arm/Right Arm *(circle one or both)*			No restriction	Frequently	Occasionally	Not at all
Repetitive use of Left hand/ Right hand *(circle one or both)*			No restriction	Frequently	Occasionally	Not at all
Keyboard/mouse			No restriction	Frequently	Occasionally	Not at all
Able to drive or operate machinery safely (to work / while at work *(Circle one or both.)*			No restriction	Frequently	Occasionally	Not at all

Comments:_____
_____
_____

❑ **OFF WORK because** of **Medical Necessity** due to: ____ Hospitalization; ___ bed rest; ____ work or commute is medically contraindicated (will worsen condition or delay recovery)

Explain (please do not include medical diagnoses)**:** _____
_____
_____
_____

Estimated date Employee may be released**:** Transitional Work / Full Duty (circle) on _____ (date)

_____ _____
Healthcare Provider (SIGNATURE) **Date**

New Form 2019.11.01