# BONNER COUNTY
# RETURN TO WORK & FITNESS FOR DUTY FORM

**THIS FORM MUST BE RETURNED TO HR/RISK DEPARTMENT!**
**FAX: 208-265-1457**
**1500 Hwy 2, #337, Sandpoint, ID 83864**

| | |
|---|---|
| **EMPLOYEE:** | **LAST EXAM DATE:** |
| **DATE OF ILLNESS/INJURY/SURGERY:** | **NEXT EXAM DATE:** |
| **EMPLOYEE'S JOB TITLE:** | **DEPARTMENT:** |

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:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Lift or Carry** | **NO RESTRICTION** | **Up to 5 lbs.** | **5-10 lbs.** | **11-25 lbs.** | **26-50 lbs.** | **NOT AT ALL** |
| **Push or Pull** | **NO RESTRICTION** | **Up to 5 lbs.** | **5-10 lbs.** | **11-25 lbs.** | **26-50 lbs.** | **NOT AT ALL** |
| **Stand/Walk** | **NO RESTRICTION** | **# of Hours:** | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Sit** | **NO RESTRICTION** | **# of Hours:** | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Stoop/Bend/Twist** | **NO RESTRICTION** | | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Kneel or Squat** | **NO RESTRICTION** | | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Climb** | **NO RESTRICTION** | | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Reach above shoulder** | **NO RESTRICTION** | **Right Arm** | **Left Arm** | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Repetitive Use of hand** | **NO RESTRICTION** | **Right Hand** | **Left Hand** | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Computer Use (Monitor)** | **NO RESTRICTION** | **# of Hours:** | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Keyboard/Mouse** | **NO RESTRICTION** | **# of Hours:** | | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Able to drive safely** | **NO RESTRICTION** | **To work** | **While at work** | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **Able to operate machinery safely** | **NO RESTRICTION** | **To work** | **While at work** | **Frequently** | **Occasionally** | **NOT AT ALL** |
| **OTHER** | **NO RESTRICTION** | **Please explain:** | | **Frequently** | **Occasionally** | **NOT AT ALL** |

**Additional Comments (Please do not include medical diagnoses):**_____

_____

_____

- **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 or Full Duty (circle) on _____ _____(date)

_____ _____

Healthcare Provider Clinic Name

_____ _____

Signature (Health Care Provider) Date

*Revised 2020.08.31*