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 WORK INJURY:		**NEXT EXAM DATE:**
EMPLOYEE'S JOB TITLE:		**DEPARTMENT:**
WC CLAIM #	**PROVIDER:**	**CLINIC:**

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

- o **FULL DUTY**, usual job, no restrictions, as of: ____(date).
- o **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):____
____
____

- o **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