

Shepherd University Medical Release to Return to Work

Patient's Name: _____ is released to return to work on _____ with the following restrictions:

_____ No restrictions required

_____ Restricted hours per day: This specified limit _____

_____ Restricted days per week: This specified limit _____

_____ Restricted weight lifting: No greater than: 50 lbs. 20 lbs. 10 lbs. 5 lbs. Other _____

Restrictions during a work shift

Bending/Stooping 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Pulling/Pushing 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Overhead Reaching 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Sitting 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Standing 0-3 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

If other limitations please specify: _____

These restrictions are to be in effect starting _____ through and including _____

These limitations are: **Permanent** **Temporary**

May resume regular duties on _____ **OR** will be re-evaluated on _____

Physician's Signature (Must be signed by physician, not staff)

Date

Name of Physician (please print)

Physician's Phone Number

I hereby grant permission for my medical records to be released to the Human Resources Office, Shepherd University, PO Box 5000, Shepherdstown, WV, 25443. (Phone 304-876-5299; Fax 304-876-5197)

Employee's Signature

Date

It is the employee's responsibility to submit this form to the Department of Human Resources prior to returning to work. Shepherd University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether requested accommodations can be met in a reasonable fashion. Employees will be notified by their supervisors if their duties can be modified to meet the restrictions described, or if such modifications cannot be made and they will need to remain off work on medical leave.