DMEC
Disability Management Employer Coalition

Return-to-Work Forms

PATIENT NAME:	AGE:	PHONE:
SUPERVISOR :	PROVIDER:	

Please indicate which requirements are essential to the job (Y=yes, N=no) and indicate under "frequency" how often it must be done (C=constant, F=frequent, O=occasional)

For each duty checked "Y", please indicate any restriction or limitations applicable. If the patient has no restrictions or limitations, please note that you are releasing them to return to full duty in the "provider notes" section below.

REQUIREMENT	DUTY	FREQUENCY	RESTRICTION *(LEAVE BLANK IF NONE)*
Work 8 hrs	Y N	Daily	
Work 5 days	Y N	Weekly	
Lift >45lbs	Y N	C F O	
Lift 15-45lbs	Y N	C F O	
Lift <15lbs	Y N	C F O	
Pulling	Y N	C F O	
Bending	Y N	C F O	
Grasping	Y N	C F O	
Walking	Y N	C F O	
Sitting	Y N	C F O	
Standing	Y N	C F O	
Keyboarding	Y N	C F O	
Speaking	Y N	C F O	
Reading	Y N	C F O	

Expected duration of any limitations:

PROVIDER NOTES:

☐ If checked, I am releasing the patient to full duty w/o restriction on ___/___/___.

PROVIDER NAME & SIGNATURE:	DATE:
	OFFICE:
	PHONE:

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PATIENT NAME:	AGE:	PHONE:

CHECK ONE OF THE FOLLOWING:

☐ Patient may return to work with no restrictions limitations on ___/___/___.

☐ Patient may return to work ___/___/___ with the following restrictions.

ACTIVITY	RESTRICTION OR LIMITATION
Duration of Work Day	
Lifting	
Duration of Standing	
Walking	
Seated	
Driving	
Activities to be avoided	
Other	

COMMENTS/NOTES:

PROVIDER NAME & SIGNATURE:	DATE:
	PHONE:

WHEN COMPLETE, RETURN TO: