BCRC
BE PART OF SOMETHING
Employment • Recovery • Community • Youth

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RETURN TO WORK REPORT

TO BE COMPLETED BY INJURED/ILL WORKER

Date of Visit ______________ Date of Injury/Illness ______________ Social Security # ______________

Employee Name ______________________________ Birth Date ______________

Address ______________________________ Phone ( ) ______________

City ______________________________ State __________ Zip __________

TO BE COMPLETED BY PHYSICIAN/HOSPITAL STAFF

☐ Initial Treatment ☐ Follow-Up visit

WORK STATUS:

☐ **Employee may return to work on ______________ with modified duties *as listed below*, effective until ______________**

- ☐ No lifting over ________lbs.
- ☐ No work above ground or surface level
- ☐ No pushing or pulling over ________ lbs.
- ☐ No work around high speed or moving machinery
- ☐ No kneeling or squatting
- ☐ No standing more than __________ at a time
- ☐ Other:
- ☐ No walking more than __________ at a time
- ☐ No reaching above shoulder level
- ☐ No repetitive bending or twisting
- ☐ No sitting more than __________ at a time
- ☐ No operating mobile equipment
- ☐ No climbing of stairs or ladders
- ☐ No driving of motor vehicle

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☐ **Employee may return to full work duties on ______________ with no restrictions or limitations.**

RECHECK: Employee will be rechecked by physician on ______________, 20____ @ Time: ____________a.m./p.m.

RECOMMENDATIONS: ____

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PHYSICIAN'S SIGNATURE ______________________________ Date ______________

PHYSICIAN'S NAME (printed) ______________________________

BCRC is an equal opportunity provider and employer. If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (PDF), found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form.