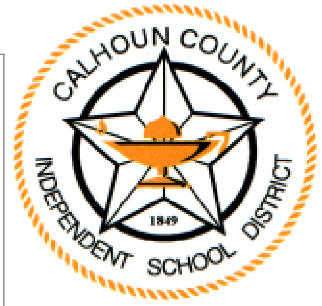
RETURN TO WORK RELEASE FORM: *CALHOUN COUNTY ISD*



TO BE COMPLETED BY THE EMPLOYEE

Name:______________________________ ID#: __________ Department: ________________________.

Supervisor: ____________________ Home Phone:_______________ Work Phone: _________________.

I understand that if my release includes workplace restrictions related to my medical condition, it must reach my supervisor **prior** to my return to work date. I understand that my return to work date may be delayed so that my department can evaluate any identified restrictions. If restrictions are substantially limiting, are expected to continue longer than 3 months or are considered permanent, your return release will be referred to the Office of Institutional Equity (OIE) for review under the ADAAA (Americans with Disabilities Act as amended).

________________________ Employee Signature ________________ Last Day Worked ______________ Date

Quality Schools

Successful Students

TO BE COMPLETED BY THE *HEALTHCARE PROVIDER*

(1) Employee may:

____Return to work on _______________ **(date)** without restrictions.

____Return to work on _______________ **(date)** with restrictions as indicated below through ____________ **(date).**

____Unable to return to work from _______________ **(date)** to _______________ **(date)** due to incapacity or restrictions.

____Restrictions listed below are **PERMANENT.**

(2) Employee may work full-time hours? ☐ **YES** ☐ **NO**

If _no_: Maximum hours/workday: _______ Maximum hours/week: __________ *Employee may be eligible for FMLA.*

(3) WORK RESTRICTIONS

*Employee **may perform activity:*** **Please answer all below**	**NONE** 0% of workday	**OCCASIONALLY** 1-33% of workday	**FREQUENTLY** 34-64% of workday	**CONSTANTLY** 65-100% of workday
Lifting maximum ________ pounds				
Pushing / pulling maximum ____ pounds				
Reaching above shoulder **R / L** (circle)				
Grasping / squeezing				
Keyboarding				
Repetitive hand / wrist motion **R / L** (circle)				
Sitting				
Standing / Walking				
Squatting / kneeling				
Repetitive bending / stooping				
Climbing stairs / ladders (circle)				

Other Restrictions (if any):____

____

Must use crutches or splint or other ☐ **YES** ☐ **NO** Specify other:	Able to drive vehicle for work purposes, if applicable ☐ **YES** ☐ **NO** ☐ **N/A**
Able to work with others: ☐ **YES** ☐ **NO**	Able to give supervision, if applicable: ☐ **YES** ☐ **NO**
No exposure to:	Consultation with a Safety professional is available upon request for chemical or lab exposure limitations. Consult requested? ☐ **YES** ☐ **NO**

Doctor Printed Name: ______________________________________ Doctor Phone: __________________________

Doctor Signature: ____ Doctor Fax: ____________________________

Today's Date: ______________________________

General Information: This form helps gather return to work information to a supervisor when returning from a leave of absence or use of Sick Leave for an employee's own medical condition. **If an alternate release form is used, please do not include diagnosis or treatment information.** This form is submitted by the employee to the employee's supervisor.