

## Return to Work Form: Medical Authorization

Name of Patient:	Patient Phone #:
Name & Title of Health Care Provider:	Physician Phone#:
Dates of Treatment/Office Visits:	Physician Fax #:

1.  Following review of the position description, I certify that in my medical opinion, this patient is unable to work from (begin date) \_\_\_\_\_ to (end date) \_\_\_\_\_

**2. For Workers' Compensation Leaves Only**

a. May return to alternate duty on (begin date) \_\_\_\_\_ to (end date) \_\_\_\_\_  
 If patient can return to alternate duty, you must complete the NYS Estimated Physical Capabilities Form.

b. Will it be necessary for the employee to work less than a full schedule or work intermittently:

No  
 Yes If yes, please explain:

3.  May return to full, unrestricted duty on \_\_\_\_\_  
 May return with restrictions on \_\_\_\_\_ **(If this box is checked, please complete questions 4-7.)**

4a. In an 8 hour workday, how many hours can this employee: (please check appropriate boxes)

Sit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Stand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Walk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests

4b. In a given day, for how many hours can this employee sit, stand, and/or walk in combination?

2 4 6 8 10 12 14 16 Greater than 16

5a. Other Capabilities: (please check appropriate boxes)

	Never	Occasionally	Frequently	Continuously
<b>Lift</b>				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Carry</b>				
0-10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50-100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5b. Upper Extremities:

Which hand is dominant?  Right  Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing and Pulling	Fine Manipulation
Right	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Left	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

5c. Lower Extremities:

Use of feet/legs for repetitive movement as in operation of foot controls and motor vehicles:

Right Extremity	Left Extremity	Simultaneously
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6. Work Environment Restrictions:

Can this employee:

- Be exposed to marked changes in temperature and humidity?  Y  N
- Be exposed to unprotected heights?  Y  N
- Be around moving machinery?  Y  N

7. Other Restrictions Explain: \_\_\_\_\_  
\_\_\_\_\_

8. \_\_\_\_\_  
Health Care Provider Signature Date

9. Authorization to Disclose Medical Records and/or Services Provided or Received. I authorize the release of any medical information necessary to process the above request.

\_\_\_\_\_  
Patient's Signature Date

Please return as soon as possible, marked CONFIDENTIAL to:

Farmingdale State College  
Human Resources  
Whitman Hall  
Farmingdale, New York 11735

Phone: (631) 420-2107  
Fax: (631) 420-2489