

MEDICAL RETURN TO WORK EVALUATION TOWN OF DAVIE

The treating PHYSICIAN must complete this type form EACH time an injured employee is treated.

Patient/Employee Name: _____ **Date:** _____

Work/Job Position: _____ **Date of Injury:** _____

Employees Department & Division: _____

TO BE COMPLETED BY PHYSICIAN

1). Is this employee able to perform his/her regular work without restriction? Yes No
(If NO Complete #2)

If Yes, Indicate date able to resume regular work assignment: _____

2). Is the employee able to perform any Light work? Yes No
If yes, check the workplace limitations that are due to the injury.

Hours a Day: _____ **or Full-Time:** _____

Type Work	Full Restriction	Partial Restriction	No Restriction
Sedentary - Lifting 0 - 10 Pounds			
Light - Lifting 10 - 20 Pounds			
Moderate - Lifting 20 - 50 Pounds			
Heavy - Lifting 50 - 100 Pounds			
Pulling/ Pushing, Carrying			
Reaching or Working Above Shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Crawling			
Repeated Bending			
Climbing			
Operating a Vehicle, Riding Mower, Tractor, Etc.			

Exposure Limitations: Heat Cold Stress Dust Fumes

3). Period of Disability (Estimated)	Date Able To Resume Work (Mo., Day, Year)
Total Disability: From _____ To _____	Light Work _____ Employee Advised? _____
Partial Disability: From _____ To _____	Regular Work _____ Employee Advised? _____

4). Diagnosis Of Injury, Treatment Plan, and Prognosis: _____

Date of Examination: _____ **Next Appointment:** _____ **Discharged:** _____

Physicians Signature: _____ **Date:** _____

Printed Name: _____