



**TOWN OF DAVIE  
MEDICAL RETURN TO WORK EVALUATION  
WORK INJURY/ILLNESS**

*The Treating PHYSICIAN must complete this form each time employee is treated*

Patient/Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Work/Job/Position: \_\_\_\_\_ Department: \_\_\_\_\_ Date of Injury / Illness: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

1. Is the employee able to perform his/her regular work without restriction?  Yes  No

If Yes, indicate date employee can return to regular work: \_\_\_\_\_

If No, complete #2:

2. Is the employee able to perform Light Duty assignments?  Yes  No

If yes, check the workplace limitations below that are due to the injury.

Number of hours a day employee is able to work: \_\_\_\_\_

<i>Type of Work</i>	<i>No Restriction</i>	<i>Partial Restriction</i>	<i>Full Restriction</i>
Sedentary – Lifting 0 – 10 Pounds			
Light – Lifting 10 – 20 Pounds			
Moderate – Lifting 20 – 50 Pounds			
Heavy – Lifting 50 – 100 Pounds (Occasional)			
Pulling / Pushing / Carrying			
Reaching or Working Above Shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Repeated Bending and Crawling			
Climbing			
Operating a Vehicle, Truck, Etc.			

Exposure Limitations:  Heat  Cold  Dust  Fumes

3. Diagnosis of Injury, Treatment Plan, and Prognosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Next Appointment: \_\_\_\_\_ Has Employee Reached MMI? \_\_\_\_\_ Discharged? \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

**Employee must return this form to their supervisor prior to going home.**