TOWN OF DAVIE
6951 Orange Drive
Davie, FL 33314
tel (954)797-1097 fax (954) 797-1079
risk@davie-fl.gov

Risk Management

Medical Return to Work Evaluation

Work Injury /Illness

Patient/Employee Name:		Date:
Job Title:	Department:	Date of Injury / Illness:

TO BE COMPLETED BY PHYSICIAN

TREATING PHYSICIAN MUST COMPLETE THIS FORM EACH TIME EMPLOYEE IS TREATED

Is the employee able to perform his/her regular work without restrictions? ☐ **YES** ☐ **NO**

IF YES – Indicate date employee can return to regular work duty: Return Date: _____

IF NO – Is the employee able to perform Light Duty assignments: ☐ NO ☐ YES, complete *Limitations* section below:

LIMITATIONS OF LIGHT DUTY WORK ASSIGNMENTS

Number of hours a day employee is able to work: _____hour(s)

TYPE OF WORK	RESTRICTIONS			COMMENTS (LOAD, FREQUENCY, DURATION, ETC.)
	NONE	PARTIAL	FULL	
Bending	☐	☐	☐	
Carrying	☐	☐	☐	
Climbing	☐	☐	☐	
Crawling	☐	☐	☐	
Kneeling	☐	☐	☐	
Lifting-floor > waist	☐	☐	☐	
Lifting-waist > overhead	☐	☐	☐	
Operating a Vehicle, Truck, etc.	☐	☐	☐	
Pulling	☐	☐	☐	
Pushing	☐	☐	☐	
Reaching-overhead	☐	☐	☐	
Sitting	☐	☐	☐	
Squatting	☐	☐	☐	
Standing	☐	☐	☐	
Twisting	☐	☐	☐	
Walking	☐	☐	☐	
Other	☐	☐	☐	

Exposure Limitations: ☐ HEAT ☐ COLD ☐ DUST ☐ FUMES

Diagnosis of Injury:

Treatment Plan:

Prognosis:

Next Appointment:_____ Has Employee Reached MMI?_____Discharged? _____

Physician Signature: _____ Date: _____

Physician Printed Name: _____ Clinic Name: _____

FAX COMPLETED FORM TO TOWN OF DAVIE RISK MANAGEMENT AT: (954) 797-1079

EMPLOYEE MUST RETURN THIS FORM TO THEIR SUPERVISOR PRIOR TO GOING HOME