JEFFERSON COUNTY
RELEASE TO RETURN TO WORK

Employee Name_____

◯ **The employee is not able to return to work.**

___ **A.** The employee is able to work a full, regular schedule with no restrictions, beginning:
_____

___ **B.** The employee is able to return to work on a reduced schedule required by this condition beginning_____ through _____with a full release on _____
Reduced schedule maximum weekly work hours _____
Reduced schedule maximum daily work hours _____

___ **C.** The employee is able to return to work with restrictions required by this condition beginning_____ through _____

Please check and describe the restrictions required by this health condition:

- ☐ Stand (# of hrs.) _____
- ☐ Walk (# of hrs.) _____
- ☐ Sit (# of hrs.) _____
- ☐ Lift (# of lbs.) _____
- ☐ Push/Pull force (# of lbs.) ___
- ☐ Use of hands/fingers (repetitive motion)
- ☐ Reach with arms/hands
- ☐ Concentrate
- ☐ Multi-task
- ☐ Communicate
- ☐ Bend, twist, stoop
- ☐ Perform manual tasks

Describe Restrictions:_____

_____

_____

_____

YES ☐ **NO** ☐ Human Resources may contact you for clarification if needed.

_____ _____
Name of Treating Healthcare Provider Signature of Treating Healthcare Provider

_____ _____
Date Phone

Once completed please submit to hr@co.jefferson.or.us