COUNTY OF TUOLUMNE
MEDICAL PROVIDER
WORK STATUS

Name:_____ Date:_____

If modified work is a possibility for workers who have injuries or illnesses, which temporarily preclude their performance of regular job duties, please indicate what the employee can and cannot do in order to place the injured worker into Tuolumne County's Return to Work Program. **FAX a copy to Human Resources/Risk Management (209) 533-5901.**

1. I release this employee to return to work on _____ with limitations listed below.
Date

Employee is to be reevaluated on _____
Date **Time**

Employee is restricted from the following, please circle those that apply:

Lifting to waist height Fine Manipulation Twisting Sitting Lifting to Shoulder Height

Pulling/Pushing Carrying Standing Lifting Overhead Bending

Grasping Climbing Reaching

No lifting over _____ lbs. Minimal use of _____

MODIFIED WORK (other than above):_____

2. This employee is completely incapacitated and cannot work. This employee is scheduled for re-evaluation on _____
Date

3. The employee is released to return to work with _____ on _____**Date**
(limitations or no restrictions)

The employee will be re-evaluated on _____
Date **Time**

4. Discharged from care. ___ Yes ___No

5. Returned to pre-injury condition ___ Yes ___No

6. Any permanent disability ___ Yes ___No
If yes, please explain:_____

7. Is the employee taking medication that could jeopardize his/her safety or that of co-workers?
____ Yes ___No
If yes, please list:_____

Medical Provider:_____ Date:_____

COPY TO: SUPERVISOR AND HUMAN RESOURCES/RISK MANAGEMENT