

RELEASE TO RETURN TO WORK

| | |
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| Name of worker | Claim number |
|----------------|--------------|

Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? Yes No If yes, date: _____ (Provide closing information and complete Form 827.)
 If no, estimated medically stationary date: _____ Are there permanent restrictions? Yes No Unknown

Next scheduled appointment date: _____

2. Worker is released to:

- full duty without limitations Date: _____ (Do not complete lines 3 through 11. Sign below.)
- modified duty from (date): _____ through (date): _____ (specify limitations below)
- modified hours specify hours: _____ from (date): _____ through (date): _____
- not released to work Est. RTW date: _____ If modified release, provide date of anticipated regular release: _____

Hours: No limitations 1 2 3 4 5 6 7 8 Other (specify)

- 3. In a/an 8 10 12 other _____ -hour workday,
 worker can stand/walk a total of _____ _____
- 4. At one time, worker can stand/walk _____ _____
- 5. In a/an 8 10 12 other _____ -hour workday,
 worker can sit a total of _____ _____
- 6. At one time, worker can sit _____ _____

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

| Pounds | <10 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 | >100 |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Occasionally | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. Worker can use hands for repetitive:
- | | | | | |
|------------------------|--|--|--|--|
| | Right | | Left | |
| a. Fine manipulation | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dominant hand |
| b. Pushing and pulling | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| c. Simple grasping | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| d. Keyboarding | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): Yes No

10. Worker is able to:

| | Continuous 67-100% of the day | Frequently 34-66% of the day | Occasionally 6-33% of the day | Intermittently 1-5% of the day | Not at all |
|---------------------|----------------------------------|---------------------------------|----------------------------------|-----------------------------------|--------------------------|
| a. Stoop/bend ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Crouch ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Crawl ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Kneel ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Twist ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Climb ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Balance ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Reach ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Push/pull ----- | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

| | | |
|--|--------------|------|
| Signature of medical service provider* | Printed name | Date |
|--|--------------|------|

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.