Diocese of Owensboro

McRaith Catholic Center

Return-to-Work Release Form

Instructions:

Immediate supervisor: Give this form to the employee with the employee's up-to-date job description attached.

Employee: Have your health care provider review your attached job description and complete this form. Return the completed form to your supervisor before you return to work.

Health care provider: Please review the attached job description for this employee, complete this form and return it to the patient.

Employee name: _____

Job title: _____

Date the condition began: _____

Please check one of the following:

- ☐ The employee is able to work a full, regular schedule with no restrictions, beginning _____(date).
- ☐ The employee is unable to return to work until _____(date).
- ☐ The employee is able to return to work on a reduced schedule for ___ hours a day from _____(date) through_____ (date).
- ☐ The employee is able to return to work with restrictions from_____ (date) through_____ (date).

Please indicate restrictions, if any, below:

Standing (number of hours): _____

Walking (number of hours): _____

Sitting (number of hours): _____

Lifting (number of pounds): _____

Carrying (number of pounds): _____

Use of hands (repetitive motions, pushing, pulling): _____

Other restrictions: _____

_____

_____

_____

Health care provider's signature: _____

Health care provider's printed name: _____

Date: _____