St. Claire HealthCare

All Release to Work forms must be submitted to & approved by HR prior to returning to work.

RELEASE TO WORK STATEMENT

Patient's Name: _____ **SSN:** _____-_____-_____

Return to full duties **without restrictions** on _____.
DATE

Return to activities **with medical restrictions**.

Start Date: _____ End Date: _____ **(Required)**

Check all that apply: **(detail is required)**

No lifting greater than _____lbs.

No use of hand(s): Right _____ Left _____ Both _____

No use of arm(s): Right _____ Left _____ Both _____

Sit down activities only.

Activity limited to: Splint _____ Brace_____ Other_____

Keep affected area clean and dry.

No repetitive bending and twisting.

No repetitive flexion / extension of Wrist(s): Right _____ Left _____ Both _____

No over shoulder activity with Arm(s): Right _____ Left _____ Both _____

Alternate Sitting/Standing every _____ minutes _____ hours.

Restrictions other than above:

_____

_____

Follow-up Appointment: _____

_____ _____

Physician's Signature **Date**