

Return form to:

Administrative Services

RELEASE TO RETURN TO WORK

Name of worker	Claim number
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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"/>	<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"/>	<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
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440-3245 (10/05/DCBS/WCD/WEB)

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