KANIKSU
COMMUNITY HEALTH

Return to Work Medical Release Form

Instructions:

Employee: Have your health care provider review your attached job description and ask him/her to complete this form. Please return the completed form to Human Resources before you return to work.
(*Please note that this form does not replace the Certification of Medical Condition that may be required for Family Medical Leave determinations as dictated by the Idaho Department of Labor.)*

Health Care Provider: Please review the attached job description for the employee and complete the form below. Thank you.

Employee Name:_____

Department:_____

Date of Condition:_____

Please check one of the following:

___The employee is able to work a full/regular shift with no restrictions as of _____(date)

___The employee is unable to return to work until _____(date).

___The employee is able to return to work on a reduced/modified schedule for ____ hours per day from:

_____(date) to _____(date).

___The employee is able to return to work with restrictions from _____(date) to _____(date).

Please Indicate restrictions, if applicable, 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)_____

Driving (Distance/Number of Hours)_____

Any other restrictions/notes:_____

_____

Signature of Health Care Provider:_____

Print Name of Provider:_____ Date:_____