**Return to Work Certification**

**Health Care Provider:** Please complete this form using extra sheets if needed and return to employee.

**Employee:** deliver completed form to LOA Department as soon as possible via fax to **(614) 238-2205** or email njapilot@harveywatt.com and keep a copy for your records. Failure to return this form in a timely manner will result in a delay to your return to work and your next scheduled paycheck.

**Employee Name (Print) ____________________________________________________________**

☐ **The above employee may return to work with NO RESTRICTIONS on _______________________.**

☐ **The above employee may return to work WITH RESTRICTIONS from ___________ to __________.**

*** Please complete the work capabilities below if there **<u>are restrictions</u>**:*

| **% of Workday or Repetitions/Hour** | **Occasionally 1-33% 4-6 times/hour** | **Frequently 34-66% 6-12 times/hour** | **Continuously 67-100% >12 times/hour** |
|---|---|---|---|
| Lift/Carry | | | |
| Up to 10 lbs | | | |
| 11-29 lbs | | | |
| 30+ lbs | | | |
| Bend | | | |
| Twist/Turn | | | |
| Reach below knee | | | |
| Lift above shoulders | | | |
| Push/Pull | | | |
| Squat/Kneel | | | |
| Stand | | | |
| Walk | | | |
| Sit | | | |
| Repetitive activities | | | |

☐ **No lifting greater than ________lbs.** **No use of ☐ Left ☐ Right ☐ Both**
**☐ Hand(s) ☐ Arm(s) ☐Leg(s) ☐Other __________.**

☐ **Change positions every ___________.** ☐ **Avoid driving/operating heavy machinery**

**These restrictions are ☐ permanent ☐ temporary. Duration if temporary: _________________.**

☐ **Follow-up appointment scheduled for ________________.**

Health Care Provider Printed Name _______________________________________________

Health Care Provider Signature ___________________________________ Date _____________

Address _______________________________________ Phone __________________________

**Employee Signature** _____________________________________________Date ____________