FOUNDED 1862

RETURN TO WORK CAPACITIES FORM

Patient Name:	Employer: Danville Community Consolidated School Dist 118
Employer Contact Name:	Phone:

Dear Doctor:

Your cooperation in completing this form is requested. This information will help us to provide useful work activity for our employee without compromising his/her recovery. Please check the appropriate information or check the "No Restrictions" box at left.

No Restrictions	Activity	Patient Can Perform the Listed Activities as Indicated
☐	1. Standing/Walking	Hours at one time: ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 4-8 Maximum daily hours: ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 4-8
☐	2. Sitting	Hours at one time: ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 4-8 Maximum daily hours: ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 4-8
☐	3. Lift/Carry/Push/Pull	Pounds: ☐ 10 ☐ 20 ☐ 50 ☐ 100 ☐ over 100 Frequency: ☐ Occasionally ☐ Frequently
☐	4. Hand/Finger Usage	☐ Right ☐ Left ☐ Simple grasping ☐ Pushing/Pulling ☐ Fine Manipulation
☐	5. Patient	☐ Can ☐ Cannot Use ☐ Right foot ☐ Left Foot for repetitive movement as in operating foot controls
☐	6. Patient	☐ Is ☐ Is not Able to ☐ Bend ☐ Squat ☐ Kneel ☐ Climb ☐ Frequently ☐ Occasionally
☐	7. Patient	☐ Is ☐ Is not Restricted by environment factors including: ☐ Temperature ☐ Humidity ☐ Dust, etc. Comments:
☐	8. Patient's	☐ Medication ☐ Treatment May affect his/her ability to work. Comments:
☐	9. Patient is	☐ Not released ☐ Released with above restrictions ☐ Released without restrictions **Date of return:**
☐	10. Patient will be seen again for re-evaluation	Date: Time:
☐	11. Additional Comments:	

Provider Facility Name (print)

Physician Signature / Date