

Workers' Compensation—Early Return to Work Program
 Sindecuse Health Center
 Phone (269) 387-3281 • Fax (269) 387-2944

Case No. _____

| | | |
|--|--|------------------|
| Patient Name (Last, First, and Middle Initial) | | Patient ID No. |
| Date of Accident/Injury | Diagnosis | Next Appointment |
| Status | <input type="checkbox"/> New Event <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Regressed <input type="checkbox"/> Resolved | |
| Work Status | <input type="checkbox"/> Return to Work on (date) _____ <input type="checkbox"/> Full Duty <input type="checkbox"/> Limited Duty: _____ hours per day Alternate Standing/Sitting: <input type="checkbox"/> At Will <input type="checkbox"/> Other: _____ <input type="checkbox"/> (Off) Unable to return to work until follow-up appointment | |

Physical Capabilities
 (check/complete only those that apply)

| Movement | Rarely Less than 1/2 hour | Occasionally 1/2 to 3 hours | Frequently 3 to 6 hours | Constantly More than 6 hours |
|------------------------------|------------------------------|--------------------------------|----------------------------|---------------------------------|
| Head extension/Flex | | | | |
| Reaching w/ arms below chest | | | | |
| Reaching w/ arms above chest | | | | |
| Stooping | | | | |
| Kneeling/Squatting | | | | |

| Activity | Rarely Less than 1/2 hour | Occasionally 1/2 to 3 hours | Frequently 3 to 6 hours | Constantly More than 6 hours |
|------------------|------------------------------|--------------------------------|----------------------------|---------------------------------|
| Pinching | | | | |
| Gripping | | | | |
| Sitting | | | | |
| Standing | | | | |
| Walking | | | | |
| Climbing | | | | |
| Bending/Twisting | | | | |

| Lifting (Pounds)—Please indicate maximum allowable in pounds | | | | |
|--|--|--|--|--|
| Single arm lift—Left | | | | |
| Single arm lift—Right | | | | |
| Double arm | | | | |
| Pushing | | | | |
| Pulling | | | | |
| Carrying | | | | |

| Repetitive Motion | | | | |
|-------------------|--|--|--|--|
| Hands/Arms | | | | |
| Feet/Legs | | | | |

Comments

| | |
|---------------------|-------------|
| Physician Signature | Date Signed |
|---------------------|-------------|

Time frames are based on an eight (8) hour workday and allocation should be distributed evenly over that period. Please adhere to these restrictions. Contact your physician with any questions. Restrictions are in effect for a maximum of thirty (30) days.

Distribution

Original: Sindecuse Health Center—Medical Records. Make **three** copies and distribute:
 Workers' Compensation Office (one copy)
 Employee (two copies—one for **employee** and one for employee to **return to his/her supervisor**).