

Medical Absence Form

Time In _____ Time Out _____
 Patient Name _____ Date of Injury _____
 Company Name _____ Date of Exam _____
 Diagnosis _____
 or Notes _____

RETURN TO WORK STATUS

_____ **May Return to work without restrictions.** _____ May not return to work until _____
 _____ May return to work with the following restrictions or recommendations:
 _____ Patient referred for Physical Therapy _____ No _____ Yes, to: _____

TASK OR PROCESS	% of Time Spent in Normal Work Shift					TASK OR PROCESS	% of Time Spent in Normal Work Shift				
	CONT 60+%	FREQ 30-60%	OCC <30%	NONE 0%	NA		CONT 60+%	FREQ 30-60%	OCC <30%	NONE 0%	NA
Lift or Carry						Vibrating Tools					
more than 50 lbs						Right Hand					
up to 50 lbs						Left Hand					
up to 40 lbs						Both Hands					
up to 30 lbs						Grip or Grasp					
up to 20 lbs						Right Hand					
up to 10 lbs						Left Hand					
up to 5 lbs						Both Hands					
						Fine Manipulation					
Push or Pull						Right Hand					
more than 50 lbs						Left Hand					
up to 50 lbs						Both Hands					
up to 40 lbs						Work Above Shoulder					
up to 30 lbs											
up to 20 lbs						Reach Forward					
up to 10 lbs											
up to 5 lbs						Work Below Waist					
						Work with Gloves					
Walk						Climb Ladders					
Stand						Climb Stairs					
Bend						Use Foot Operated Machinery					
Stoop											
Kneel						Right Foot					
Crawl						Left Foot					
Sit						Both Feet					
						Drive Lift Truck/ Tow Motor					

CONTINUOUSLY / FREQUENTLY / OCCASIONALLY / NONE

_____ Other _____ Restricted until _____
 _____ Next Clinic Appt. _____

Notes _____

 Physician's Signature