



Physician Return to Work Authorization – Physical Health

Directions: To be completed by the employee's health care provider in anticipation of employees return to work from medical leave.

Submit to: AACPS Office of Integrated Disability & Leave Management, 2644 Riva Road, Annapolis, MD 21401; **e-fax: 443-458-0140.**

Employee Name	Date of Birth	Job Title
Doctor's Name	Next Scheduled Appointment	
Body Part(s) Involved		

<input type="checkbox"/> The patient may return to work without any limitations on _____ Date	<input type="checkbox"/> The patient may return to work with limitations on _____ Date
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☐ The patient can return to work **Part-time** _____ hours/week for _____ (duration)

If there are any limitations, ALL boxes below must be filled out.

Limitations (if applicable)

		No Limitations	Frequently (3-5 hours)	Occasionally (1-3 hours)	Not at all
1 Patient may:	a. sit				
	b. stand				
	c. walk				
2 Patient may lift:	a. Sedentary to 10 lbs.				
	b. Light 10-20 lbs.				
	c. Medium 20-50 lbs.				
	d. Heavy 50-100 lbs.				
	e. Very heavy 100+ lbs.				
3 Patient may carry:	a. Light 0-10 lbs.				
	b. Medium 10-25 lbs.				
	c. Heavy 25-50 lbs.				
	d. Very heavy 50+ lbs.				
4 Patient may:	a. Push				
	b. Pull				
	c. Twist				
	d. Climb				
	e. Balance				
	f. Stoop				
	g. Kneel				
	h. Crawl				
	i. Reach				
	j. Grasp				
	k. Typing				
5 Patient may drive:	a. With clutch				
	b. Without clutch				
	c. Heavy equipment				
6 Patient may perform repetitive movement					

Please explain further any of the limitations marked above.

Are these limitations: ☐ Temporary ☐ Permanent

If temporary, for how long?

Specify any environmental requirements or assistive devices, e.g. crutches, sling, boot, cane, etc.

Signature of Doctor

Date

Phone Number

Address

Fax Number