RETURN TO WORK STATUS FORM

TO: EXAMINING HEALTH CARE PROVIDER   RE: ____________________
                                              Name of Employee

FROM: ____________________   ____________________
Name of State Agency   Employee ID #

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at this agency. The information you provide on this form is vital to us regarding the:

A. employee's working without risk of further injury;
B. provision of a temporary duty assignment if necessary that meets the employee's needs and the needs of this agency;
C. provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions regarding the information requested on this form, please contact:

Carolina Bryan, HR Specialist   (409) 880-8375
Name and Title   Phone Number

TO BE COMPLETED BY PHYSICIAN:
(See reverse side for physical requirements of employee's duties.)

Considering this employee's job duties and health condition, this employee may perform work in the following manner:

___ FULL DUTY (no restrictions) beginning: ____________________
Date

___ TEMPORARY ASSIGNMENT (Modified or Alternate Duty) beginning: ____________________
Date

Estimated Length of Temporary Assignment: ____________________
☐ Full-Time ☐ Part-Time (_____ hours per day)
(Please indicate restrictions to duty on reverse side)

___ OFF WORK until re-evaluated, beginning on: ____________________
Date

Date of next office visit: ____________________
Date

____________________   ____________________
Physician's Signature   Date

FOR AGENCY USE:

Temporary Duty Assignment Begins: ____________________ Ends: ____________________
Temporary Duty Assignment:
____
The specific duties of the temporary assignment must be provided in a written offer of employment.

EMPLOYEE INSTRUCTIONS:

Return this form to your supervisor immediately after each visit to your health care provider.