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
Name and Title

(409) 880-8375
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.