Oregon TECH
Human Resources

Employee Release to Return to Work

Return form to: Oregon Institute of Technology
3201 Campus Drive, Snell 107
Klamath Falls, OR 97601
Phone: 541-885-1028
Fax: 541-851-5200

Employee _____ ID # _____
Position/Job _____

SECTION 1: WORK STATUS *(Select one)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): _____ to: _____
Released to the ***hours routinely worked and tasks routinely performed in job at the time of injury/illness.***

☐ **OPTION 2 – Not Released to Work** Status from (date): _____ to: _____
The employee is ***not capable of performing any work activities.***

☐ **OPTION 3 – Released to Modified Work** Status from (date): _____ to: _____
Released to work, ***subject to the following work restrictions/limitations (note only those applicable):***

Total work hours: _____ hours/day _____ days/week

SECTION 2: PHYSICAL COMPONENTS

Does employee have any physical conditions which would impact return to work? ☐ Yes ☐ No
If none, please skip to Section 3: Cognitive/Psychological Components
Is the employee expected to materially improve from medical treatment or the passage of time? ☐ Yes ☐ No

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Carry:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Push:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time
Pull:	____ pounds	____ pounds	____ pounds	____ pounds	____ hrs./day	____ hrs./one time

Activity restrictions

Stand:	____ hrs./day	____ hrs./one time	
Walk:	____ hrs./day	____ hrs./one time	
Sit:	____ hrs./day	____ hrs./one time	
Drive:	____ hrs./day	____ hrs./one time	
Kneel:	____ hrs./day	____ hrs./one time	
Twist:	____ hrs./day	____ hrs./one time	
Climb:	____ hrs./day	____ hrs./one time	
Bend:	____ hrs./day	____ hrs./one time	
Crawl:	____ hrs./day	____ hrs./one time	
Crouch:	____ hrs./day	____ hrs./one time	
Balance:	____ hrs./day	____ hrs./one time	
Above shoulder reach:	____ hrs./day	____ hrs./one time	
Below shoulder reach:	____ hrs./day	____ hrs./one time	

Hand use restrictions

Fine actions:	____ hrs./day L hand	____ hrs./day R hand
Keyboarding:	____ hrs./day L hand	____ hrs./day R hand
Grasp:	____ hrs./day L hand	____ hrs./day R hand
Climb:	____ hrs./day	____ hrs./one time

Foot use restrictions

Raise	____ hrs./day L foot	____ hrs./day R foot
Push:	____ hrs./day L foot	____ hrs./day R foot

SECTION 3: COGNITIVE/PSYCHOLOGICAL COMPONENTS

Does employee have any cognitive or psychological conditions which would impact return to work? *If no, please skip to Section 4: Other Restrictions*	☐ Yes ☐ No
Is the employee expected to materially improve from treatment or the passage of time?	☐ Yes ☐ No
Statement of psychological/cognitive diagnosis(es) (include DSM-V diagnosis):	
How often is employee receiving treatment from you and/or another health care provider for this condition?	
Please identify functional limitations of diagnosis(es) based on current status of employee:	
Employee has the ability to meet the cognitive demands of the job as described in the position description.	☐ Yes ☐ No
Employee has the ability to meet the psychological demands of the job as described in the position description.	☐ Yes ☐ No
Employee has the ability to multitask without significant loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources.	☐ Yes ☐ No
Employee has the ability to work and sustain attention with distractions and/or interruptions.	☐ Yes ☐ No
Employee is able to interact appropriately with a variety of individuals including students, customers, clients, colleagues, and the public.	☐ Yes ☐ No
Employee is able to deal with people under challenging circumstances.	☐ Yes ☐ No
Employee has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships.	☐ Yes ☐ No
Employee is able to maintain regular attendance and be punctual.	☐ Yes ☐ No
Employee is able to understand, remember and follow simple verbal and written instructions.	☐ Yes ☐ No
Employee is able to understand, remember and follow detailed verbal and written instructions.	☐ Yes ☐ No
Employee is able to complete assigned tasks with minimal or no supervision.	☐ Yes ☐ No
Employee is able to exercise independent judgement and make decisions.	☐ Yes ☐ No
Employee is able to perform under stress and/or in emergencies.	☐ Yes ☐ No
Employee is able to perform in situations requiring speed or productivity quotas.	☐ Yes ☐ No
Clarify or add any additional information here:	

SECTION 4: OTHER RESTRICTIONS

If there are other job restrictions you have not described elsewhere, please describe here:	
Is the employee currently prescribed medication that would impair job function or safety? If so, please describe:	
Are all listed work restrictions medically necessary?	☐ Yes ☐ No

SECTION 5: CERTIFICATION

I certify that the information provided in this form is true and correct to the best of my knowledge.

Medical provider's signature: _____ Date: _____

Print provider's name: _____ Phone: _____