Anchorage School District

Benefits Department

5530 E. Northern Lights Blvd • Anchorage, AK 99504 • 907-742-4132 • www.asdk12.org

***Note to Supervisor and Employee*:** Employee is not allowed back on the job site until this form has been reviewed and approved for return to work. The Benefits Generalist, Leave Management will contact the supervisor to facilitate the review and approval process. **Fax this form to (907) 742-4008 or hand-deliver the form to the Benefits Department.**

Employee Work Status (Return to Work)

Employee Name: _____

☐ **Unable** to return to work until _____

☐ Can return to work with **no restrictions** on: _____

☐ Can return to **modified work** on: _____ adhering to **restrictions** checked below:

Physical Capacity Restrictions

All sections must be completed by the treating physician

NOTE: **OCCASIONALLY** (UP TO 2 HOURS PER 8-HOUR DAY) **FREQUENTLY** (UP TO 4 HOURS PER 8-HOUR DAY)

Lift/Carry	Not At All	Occasionally	Frequently	No Restrictions
0 – 3 lbs.	_____	_____	_____	_____
4 - 10 lbs.	_____	_____	_____	_____
11 - 20 lbs.	_____	_____	_____	_____
21 - 40 lbs.	_____	_____	_____	_____
Over 40 lbs.	_____	_____	_____	_____
Able To Do				
Bending	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Pushing/Pulling	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____
Repetitive hand motion	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Drive	_____	_____	_____	_____

_____ Keep wound/dressing clean & dry _____ Use assistive devices: sling, brace, crutches, etc.

_____ Avoid contact with chemicals _____ can do data entry _____ hours at a time

Other _____

Describe how any prescribed medications would adversely affect the performance of essential job functions:

_____

Follow-Up Care

_____ Final visit, discharge from care for this injury/illness Re-Evaluation on _____

_____ Physical Therapy prescribed: Frequency _____ Duration _____

Comments: _____

Physician Printed Name: _____ Date: _____

Physician Signature: _____ Date: _____

Benefits Dept. Signature: _____ Date: _____