

**State of Oklahoma
Workers' Compensation Return to Work Form**

Employee's Name: _____ Appt. Date: _____

SSN: _____ Date of Injury: _____ Employer: _____

Brief diagnosis of injury/illness: _____

RETURN TO WORK STATUS

Release: (check only one)

1. Patient is unable to return to work.
2. **Full Duty Release:** employee has reached maximum medical improvement (MMI) and is released from active medical care.
3. **Full Duty Release without Temporary restrictions:** employee is able to work full duty without restrictions, but is not released from active medical care.
4. **Light Duty Release with Temporary Restrictions:** employee has NOT reached (MMI) and can return to Light Duty Work with the following temporary restrictions: (COMPLETE RESTRICTIONS SECTION)
5. Will medication use prohibit driving or operation of heavy equipment? Yes NO

Restrictions: (check all that apply and fully describe below)

No Restrictions Temporary Restrictions Permanent Restrictions

1. Restricted lifting/carrying (maximum weight in pounds) _____ other _____ frequency _____
2. Restricted pushing/pulling of _____ lbs.
3. Restricted reaching: above chest _____ overhead _____ away from body _____ other _____
4. Restricted to one-handed duty. No use of: right hand _____ left hand _____
5. Restricted: walking standing sitting (describe) _____ partial wt bearing (describe) _____
6. Wear splint at: all times work at night (describe) _____
7. No more than _____ repetitive movements per day or hour of :
Hand Grasp L R Wrist L R Elbow Flexion L R Shoulder L R Foot L R
 Torso Flexion
8. DO NOT: Operate Machinery Crawl Kneel Squat
Drive any vehicle Climb Bend Stoop
9. Fully describe restrictions (i.e. duration, nature of limitation, etc.) add extra pages if needed:

Patient requires follow up treatment on: Date: _____ Time: _____

Medications: _____

Physician's notes: _____

Physician's Signature: _____ Date: _____

Address: _____