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: __________________________________________________________________________________________