Geneseo Return to Work Form: Medical Authorization

Name of Patient:	Patient Phone #:
Name & Title of Health Care Provider:	Physician Phone#:
Dates of Treatment/Office Visits:	Physician Fax #:

1. ☐ Following review of the position description, I certify that in my medical opinion, this patient is unable to work from (begin date) _____ to (end date) _____.

2. **For Workers' Compensation Leaves Only**

☐ a. May return to alternate duty on (begin date) _____ to (end date) _____.

If patient can return to alternate duty, you must complete the NYS Estimated Physical Capabilities Form.

b. Will it be necessary for the employee to work less than a full schedule or work intermittently:

☐ No

☐ Yes If yes, please explain:

3. ☐ May return to full, unrestricted duty on _____.

☐ May return with restrictions on _____. (**If this box is checked, please complete questions 4-7.)**

4a. In an 8 hour workday, how many hours can this employee: (please check appropriate boxes)

Sit	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests
Stand	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests
Walk	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests

4b. In a given day, for how many hours can this employee sit, stand, and/or walk in combination?

☐2 ☐4 ☐6 ☐8 ☐10 ☐12 ☐14 ☐16 ☐Greater than 16

5a. Other Capabilities: (please check appropriate boxes)

	Never	Occasionally	Frequently	Continuously
Lift				
0-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
Carry				
0-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐
50-100 lbs	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

5b. Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing and Pulling	Fine Manipulation
Right	☐Y ☐N	☐Y ☐N	☐Y ☐N
Left	☐Y ☐N	☐Y ☐N	☐Y ☐N

5c. Lower Extremities:

Use of feet/legs for repetitive movement as in operation of foot controls and motor vehicles:

Right Extremity	Left Extremity	Simultaneously
☐Y ☐N	☐Y ☐N	☐Y ☐N

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6. Work Environment Restrictions:

Can this employee:

Be exposed to marked changes in temperature and humidity? ☐ Y ☐ N

Be exposed to unprotected heights? ☐ Y ☐ N

Be around moving machinery? ☐ Y ☐ N

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7. Other Restrictions Explain:_____

_____

8._____

Health Care Provider Signature Date

9. Authorization to Disclose Medical Records and/or Services Provided or Received. I authorize the release of any medical information necessary to process the above request.

_____

Patient's Signature Date

Please return as soon as possible, marked <u>CONFIDENTIAL</u> to:

SUNY Geneseo
Human Resources – Erwin 219
1 College Circle
Geneseo, New York 14454

Phone: 585.245.5616
Fax: 585.245.5998