Return form to:

RELEASE TO RETURN TO WORK

Name of worker	Claim number

Please fill out this form and return it to us at the address indicated above.

1. Is the worker medically stationary? ☐ Yes ☐ No If yes, date: __________ (Provide closing information and complete Form 827.)

   If no, estimated medically stationary date: __________ Are there permanent restrictions? ☐ Yes ☐ No ☐ Unknown

   Next scheduled appointment date: __________

2. Worker is released to:

   ☐ full duty without limitations Date: __________ (Do not complete lines 3 through 11. Sign below.)

   ☐ modified duty from (date): __________ through (date): __________ (specify limitations below)

   ☐ modified hours specify hours: __________ from (date): __________ through (date): __________

   ☐ not released to work Est. RTW date: __________ If modified release, provide date of anticipated regular release: __________

	Hours: **No limitations**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Other (specify)**
3. In a/an ☐ 8 ☐ 10 ☐12 ☐ other _____ -hour workday, worker can stand/walk a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ __________
4. At one time, worker can stand/walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ __________
5. In a/an ☐ 8 ☐ 10 ☐ 12 ☐ other _____ -hour workday, worker can sit a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ __________
6. At one time, worker can sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ __________

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	**<10**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**>100**
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:	**Right**	**Left**	
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No	Dominant hand
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No	
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:	**Continuous** **67-100% of the day**	**Frequently** **34-66% of the day**	**Occasionally** **6-33% of the day**	**Intermittently** **1-5% of the day**	**Not at all**
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Climb	☐	☐	☐	☐	☐
g. Balance	☐	☐	☐	☐	☐
h. Reach	☐	☐	☐	☐	☐
i. Push/pull	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of medical service provider*	Printed name	Date

440-3245 (10/05/DCBS/WCD/WEB)

* See OAR 436-010-0210 regarding who may provide medical services and authorize time loss.