RETURN TO WORK STATUS FORM

TO: **EXAMINING HEALTH CARE PROVIDER** RE: _____
Name of Employee

FROM: _____ _____
Name of State Agency Employee ID #

It is our desire to assist our employee and your patient to return to work as soon as possible and to assist him/her in performing essential job functions at this agency. The information you provide on this form is vital to us regarding the:

A. employee's working without risk of further injury;
B. provision of a temporary duty assignment if necessary that meets the employee's needs and the needs of this agency;
C. provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

If you have any questions regarding the information requested on this form, please contact:

Carolina Bryan, HR Specialist **(409) 880-8375**
Name and Title Phone Number

TO BE COMPLETED BY PHYSICIAN:
(See reverse side for physical requirements of employee's duties.)

Considering this employee's job duties and health condition, this employee may perform work in the following manner:

___ **FULL DUTY** (no restrictions) beginning: _____
Date

___ **TEMPORARY ASSIGNMENT** (Modified or Alternate Duty) beginning: _____
Date

Estimated Length of Temporary Assignment: _____
☐ Full-Time ☐ Part-Time (_____ hours per day)
(Please indicate restrictions to duty on reverse side)

___ **OFF WORK** until re-evaluated, beginning on: _____
Date

Date of next office visit: _____
Date

_____ _____
Physician's Signature Date

FOR AGENCY USE:

Temporary Duty Assignment Begins: _____ Ends: _____
Temporary Duty Assignment:
_____
The specific duties of the temporary assignment must be provided in a written offer of employment.

EMPLOYEE INSTRUCTIONS:

Return this form to your supervisor immediately after each visit to your health care provider.
