

WALWORTH COUNTY RETURN TO WORK FORM

Fitness for Duty Authorization – Non-Work Related Condition

This form is to assist **Walworth County** to place workers with **non-work related health issues** into suitable work within the limitations described by a Medical Provider or to verify the ability to return to work after days off due to a personal medical condition.

ALTHOUGH NOT GUARANTEED, IF AVAILABLE, LIGHT DUTY WORK WILL BE ASSIGNED PER THE WORK RESTRICTIONS LISTED BELOW.

Walworth County Human Resources (262) 741-7950 • FAX: (262) 741-7948

Date/Time of Visit: _____

Next physician's appointment:
Date: _____ Time: _____

Next therapy appointment:
Date: _____ Time: _____

PATIENT'S NAME:
CLINIC OR HOSPITAL NAME/ADDRESS:
DATE INJURY/ILLNESS/CONDITION BEGAN:

The patient whose name appears in the boxed area was seen for:

- Treatment of Initial Injury/Illness/Condition
- Follow-up Care for a Previously Reported Injury/Illness/Condition

The patient is:

- DISCHARGED FROM CARE**
- Able to Return to Full Work on (Date) _____ Is Working
- Unable to Work From _____ Through _____

Because of: _____

- Able to Return to Limited Work (See Work Limitations Below) Will require continued restrictions due to pregnancy.
- From _____ Through _____

Medication Restrictions:

- Must Take Prescription Medication(s) Yes No
- Advised to Take Over the Counter Medication(s) Yes No
- Medication May Make Drowsy (Possible Safety/Driving Issues) Yes No

Work Limitations:

- Restricted Lifting
 - Pushing, Pulling
- | | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| MAXIMUM WEIGHT IN POUNDS | | | | |
| <input type="checkbox"/> 10 | <input type="checkbox"/> 20 | <input type="checkbox"/> 30 | <input type="checkbox"/> 40 | <input type="checkbox"/> 50 |

- Restricted Bending
- | | | | |
|------------------------------|------------------------------|-------------------------------|--------------------------------|
| MAXIMUM NO TIMES PER HOUR | | | |
| <input type="checkbox"/> 0-2 | <input type="checkbox"/> 2-6 | <input type="checkbox"/> 6-10 | <input type="checkbox"/> 10-20 |

- | | | |
|--------------------------------|--------------------------------|-------------------------------|
| DEGREE OF BEND | | |
| <input type="checkbox"/> 10-20 | <input type="checkbox"/> 20-45 | <input type="checkbox"/> Full |

- No Climbing or Overhead Work
- No Operation of Heavy Equipment
- No Operation of Moving Equipment
- Sit/Stretch Breaks of _____ per _____
- Other Limitations: _____
- Right Hand Work Only
- Left Hand Work Only
- Sitting Job Only
- No Repetitive Motions of:
 - 1. Hand Grasp
 - 2. Wrist Motion
 - 3. Elbow Flexion
 - 4. Foot Controls

Comments:

PHYSICIAN'S SIGNATURE _____