



**PUTNAM COUNTY  
RETURN TO WORK CERTIFICATION**

Date: \_\_\_\_\_ Department: \_\_\_\_\_

Employee: \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Description of Injury/Illness: \_\_\_\_\_

Physician's Name and Address: \_\_\_\_\_

Employer Signature \_\_\_\_\_

PHYSICIAN SECTION

Date of Treatment: \_\_\_\_\_ Arrival Time: \_\_\_\_\_ Discharged Time: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment Rendered: \_\_\_\_\_

Patient on **NO WORK** status.

Patient released to return to work. Date released: \_\_\_\_\_

Any medical restrictions?  yes  no

**If any restrictions upon return to work, please complete work status below:**

- No driving.
- No/limited bending, twisting, lifting, pulling, or pushing over \_\_\_\_\_ lbs.
- No/limited sitting, standing, squatting for more than \_\_\_\_\_ hours/minutes every \_\_\_\_\_ hours/minutes.
- No/limited use of R/L (hand, arm, foot, leg).
- No/limited repetitive use of injured site.
- No operating heavy equipment or power tools.
- No climbing.
- Wound must be kept clean and dry.
- Must wear eye patch.
- Must wear splint.
- Must use crutches.
- Apply hot/cold pack every \_\_\_\_\_ hours/day(s) for \_\_\_\_\_ minutes.
- Restrictions of work time to \_\_\_\_\_ hours/day(s) \_\_\_\_\_ day(s)/week(s) \_\_\_\_\_ shift.
- Medication  May cause drowsiness  No driving/operating machinery  Avoid sunlight
- Other \_\_\_\_\_

Date of next appointment \_\_\_\_\_

Physician Name (Please Print) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date Signed \_\_\_\_\_