DENVER HEALTH
Level One Care for ALL

Employees must provide management with 48 hours return to work notice and must submit this form prior to their return.

Release to Return to Work

(*Not to be used for Worker's Compensation cases)*

Employee Name (print please):_____

After examination and/or treatment, I recommend:

☐ Patient to return to work full duty/without restriction on (date): _____

☐ Part-time, _____ hours per day

☐ Return to work with the following restrictions on (date): _____

☐ No driving of vehicles
☐ No climbing ladders or working at heights
☐ No takedown or restraint of individuals
☐ Change positions frequently
☐ Integrate stretch breaks into work routine
☐ No operation of machinery
☐ Must wear / use _____at work
☐ Limit keyboard / mousework to ____ minutes/hour
☐ Alternate tasks to avoid prolonged repetitive activities

Weight Limitation (Pounds)	**Infrequent 6% of 8 hour day**	**Occasional 33% of 8 hour day**	**Frequent 66% of 8 hour day**	**Continuous >66% of 8 hour day**	**Unable**
Push					
Pull					
Carry					
Lift to waist height					
Lift to shoulder height					
Lift above shoulder height					

These restrictions will last until (date): _____

☐ Patient is NOT to return to work. Re-evaluation for return to work will be determined at next follow-up appointment scheduled for _____.

Anticipated return to work date is _____.

☐ It is not expected that this employee will be able to return to work within the next ☐ 3 months; ☐ 6 months; ☐ 12 months; ☐ other _____.

☐ I have reviewed this employee's job description and am aware of the physical demands of the position. (*Employees please provide job description)*

_____ _____
Health Care Provider Signature Date

_____
Health Care Provider Name Printed

For Internal Use Only: Management, please forward this form to the Employee Relations department via scanning to email to **LOAFMLProcess**@dhha.org or via fax at 303-602-4944.