**RELEASE TO RETURN TO WORK**

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:

<table>
<thead>
<tr>
<th>Hours</th>
<th>No limitations</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Other (specify)</th>
</tr>
</thead>
</table>

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:
   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:
    a. Stoop/bend __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    b. Crouch __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    c. Crawl __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    d. Kneel __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    e. Twist __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    f. Climb __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    g. Balance __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    h. Reach __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all
    i. Push/pull __________  [ ] 67-100% of the day  [ ] 34-66% of the day  [ ] 6-33% of the day  [ ] 1-5% of the day  [ ] Not at all

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

| Additional comments may be written on back of form. |

<table>
<thead>
<tr>
<th>Signature of medical service provider*</th>
<th>Printed name</th>
<th>Date</th>
</tr>
</thead>
</table>

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

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