[Company Logo] **Company Name**

Short Term Work Form

Doctor Approved Short Term Alternate Duty Program

Employee Name: ______________________________ **Date:** __________________________

Company name is a company dedicated to minimizing the human and financial cost of injury and disability by developing an individualized, safe and timely process for employee return to work.

We offer upon medical opinion suitable alternate work for work-and non work-related incidents.

Please have your Doctor fill out the attached forms and return them immediately to your supervisor or bring them into the office. Please discuss the alternate job list with your Doctor and identify any areas that require further modification.

The following individuals are available to answer any questions you may have concerning this process:

Management representatives are:

Manager _________________________________ **Phone** ___________________________

Supervisor _________________________________ **Phone** ___________________________

Note to Physician

Physician:

To assist us in facilitating a safe and timely return to work for our employee, your assistance in completing the attached form would be greatly appreciated. Please return the completed form to:

Contact: ______________________________

Company: ______________________________

Address: ______________________________

Phone: ______________________________

Cellular: ______________________________

[Company Logo] **Company Name**

Physician's Assessment of Employee's Return to Work

Worker's Name: ____________________________ **Date of Injury/Illness:** ____________________

☐ It is recommended for the employee to access additional treatment

☐ Physiotherapy ☐ Chiropractic ☐ Massage Therapy ☐ Athletic Therapy ☐ Other ________

☐ The employee can return to work with consideration that symptoms may limit certain work tasks.

☐ The employee can return to work with the following restrictions:

Walking	☐ Restricted to less than 1 hour		
	☐ Restricted, other – please specify: _____		
	☐ **As Tolerated**		
Standing	☐ Restricted to less than 1 hour		
	☐ Restricted, other – please specify: _____		
	☐ **As Tolerated**		
Sitting	☐ Restricted to less than 1 hour		
	☐ Restricted, other – please specify: _____		
	☐ **As Tolerated**		
Bending and Twisting	☐ No bending or twisting		
	☐ Restricted, other – please specify: _____		
	☐ **As Tolerated**		
Lifting floor to waist	☐ No lifting		
	☐ No lifting over 20 lbs.	☐ No lifting over 40 lbs.	☐ No lifting over 60 lbs.
	☐ **As Tolerated**		
Lifting waist to head	☐ No lifting		
	☐ No lifting over 20 lbs.	☐ No lifting over 40 lbs.	☐ No lifting over 60 lbs.
	☐ **As Tolerated**		
Carrying	☐ No carrying		
	☐ No carrying over 20 lbs.	☐ No carrying over 40 lbs.	
	☐ **As Tolerated**		
Gripping / Pulling	☐ No gripping/pulling		
	☐ No gripping/pulling > 2 hrs/day	☐ No gripping/pulling > 4 hrs/day	
	☐ **As Tolerated**		

Climbing Stairs / Equipment	☐	Restricted, please specify: _____
	☐	**As Tolerated**
Equipment Operation	☐	Prescription medication prohibits driving
	☐	No night time driving / equipment operation
Other Comments / Recommendations (Please specify, i.e. medication side effects.)		

The following is a list of jobs that may be included in a person's return to work program understanding that these can be altered further based on medical opinion on the needs of the injured worker to accomplish a successful return to work accommodation:

-
-
-
-
-
-
-
-

The employee may be an extra person while on the program. Depending on the employee's qualifications, other tasks may be incorporated into the program. The program could consist of short periods of time on a variety of tasks that will aim at getting the employee back to their regular job.