

The University of Texas at Dallas
Return to Work Certification

Employee Name: _____ Date of Injury _____ Type of Injury _____
Department _____ Job Title _____

- Able to return to **Full Duty** on _____
- Able to return to or continue on **Modified Duty** within restrictions outlined below on _____
- Unable** to return to workplace at this time. Anticipate release for return to work by _____
- Restrictions listed below are judged to be **Permanent**

Current Work Restrictions

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Additional Rest Breaks needed:
__a) __minutes every __hours | <input type="checkbox"/> Limited Walking:
__a) assistive device for mobility _____
__b) slowed pace of walking
__c) __minutes continuous walking |
| <input type="checkbox"/> Limited Standing:
__a) Duration _____
__b) Alter posture every _____ | <input type="checkbox"/> Limited Sitting:
__a) Duration _____
__b) Alter posture every _____ |
| <input type="checkbox"/> Limited Pushing, Pulling:
__a) Rarely (less than 1/4 of time)
__b) Occasionally (less than 1/3 of time)
__c) Frequently (1/2 or more of time)
__d) Maximum pushing/pulling (lbs): _____ | <input type="checkbox"/> Limited Lifting:
__a) Rarely (less than 1/4 of time)
__b) Occasionally (less than 1/3 of time)
__c) Frequently (1/2 or more of time)
__d) Maximum lifting (lbs): _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10 20 30 40 50 60 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10 20 30 40 50 60 |
| <input type="checkbox"/> Limited Shoulder/Arm/Hand use:
__a) No reaching overhead
__b) No extreme reaching away from the body
__c) Avoid repetitive use of injured hand(s)
__d) Use injured hand as an assist only
__e) Use protective splint/device on injured hand/arm | <input type="checkbox"/> Unable to:
__a) Operate motor vehicles/forklift
__b) Operate power tools/machinery
__c) Climb ladders
__d) Work in Confined Spaces
__e) Squat
__f) Crawl |
| <input type="checkbox"/> Limited Bending:
__a) Bend from knees only
__b) Avoid bending with lifting
__c) No sustained bending
__d) Limit bending to _____ times per shift | Other Restrictions/Comments:

_____ |

Follow-up visit with Dr. _____ on _____

Attending Physician _____ Date _____ Time _____