|  |
| --- |
| Description: DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATIONSICK LEAVE/RETURN TO WORK FORM |
|  |  |
| Employee’s Name: |       |
| Patient’s Name (if different from employee): |       |
| Relationship to Employee: |       |
| Date of Appointment: |       |
| Reason for absence from work: |
| [ ]  | Medical appointment for employee |
| [ ]  | Medical appointment for employee’s family member |
| [ ]  | Personal illness, injury, or condition of employee |
| [ ]  | Illness, injury, or condition of employee’s family member |
| Please describe the illness, injury, or condition that supports the employee’s need for absence from work and how the illness/injury/condition prevents the employee from performing the essential functions of his/her job. (Let us know if you need the employee’s job essential functions.) If the employee’s absence is to care for or assist a family member, please describe the illness/injury/condition that requires the employee’s care and explain the need for the employee’s presence to care for the family member. |
|       |
| How much time do you anticipate the employee will need to be absent from work directly related to the situation described above? |
|       |  |       |  |
| Date | to | Date |
| Is the employee able to return to work without restrictions? |
| [ ]  | No. ***Please proceed to second page of this form and complete as necessary.*** |
| [ ]  | Yes, can return without restrictions on the following date |       |
|  |  |       |
| Signature of Health Care Provider |  | Type of Practice |
|       |  |       |
| Printed Name of Health Care Provider |  | Telephone Number |
|       |  |       |
| Address |  | Date |

NOTE: The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services

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| Description: DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATIONSICK LEAVE/RETURN TO WORK FORM |
| EMPLOYEE’S NAME: |       | DATE OF APPOINTMENT: |       |
|  |
| **DESCRIBE THE REASON FOR WORK RESTRICTIONS (ILLNESS/INJURY/CONDITION):** |
|       |
|  |
| **MEDICAL STATUS:** | [ ] MAX. MED. IMPROVEMENT | [ ] IMPROVED | [ ] SAME | [ ] WORSE |
|  |
|  **RETURN TO WORK STATUS (TEMPORARY MODIFIED DUTY MAY BE AVAILABLE WITH CERTAIN RESTRICTIONS)** |
| [ ] CAN RETURN TO WORK WITH RESTRICTIONS FOR FULL DAYS ON FOLLOWING DATE:  |       |
| [ ] CAN RETURN TO WORK WITH RESTRICTIONS FOR       HOURS PER DAY ON FOLLOWING DATE: |       |
|  |
| **PATIENT CAN, IN A DAY:** | MUST | (HOURS AT ONE TIME) |  | (TOTAL HOURS DURING DAY) |
|  | AVOID | 0-2 | 2-4 | 4-6 | 6-8 | 8-10 |  | 0-2 | 2-4 | 4-6 | 6-8 | 8-10 | 10-12 |
| STAND/WALK | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| SIT | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| DATA ENTRY/TYPING | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| SIMPLE GRASPING | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| TWIST | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| BEND | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| SQUAT | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| KNEEL | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| CLIMB | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| REACH | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| JACK HAMMER | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| PUSHING & PULLING       LBS. | [ ]  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | [ ]  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| OPERATE FOOT CONTROLS | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| DRIVE CAR/TRUCK | **[ ]**  | NO RESTRICTIONS | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| [ ] AUTOMATIC [ ] STANDARD/MANUAL |
|  |
| **PATIENT HAS THE FOLLOWING LIFTING RESTRICTIONS:** | **[ ]**  NO LIFTING RESTRICTIONS |
| FLOOR TO WAIST       LBS.  | WAIST TO SHOULDER       LBS. |
| SHOULDER TO OVERHEAD       LBS. | CARRY       LBS. |
| **OTHER PHYSICAL RESTRICTIONS AND/OR INSTRUCTIONS:** |
|       |
|  |
| **LIST ANY RESTRICTIONS AND/OR INSTRUCTIONS RELATED TO ANY PRESCRIPTION MEDICATIONS:** |
|       |
|  |  |       |
| SIGNATURE OF HEALTH CARE PROVIDER |  | DATE |
|  |
| NEXT APPOINTMENT DATE:  |       |