UNIVERSITY of ROCHESTER

Return to Work Program

WORK ACCOMMODATION FORM

Employee: _____ **DOB:** _____ **Date:** _____

Patient is released to work as of: Date_____ ☐ **WITHOUT Restrictions** ☐ **WITH Restrictions stated below**

Return to work program is not appropriate at this time (Please explain**):** _____

_____

******PLEASE COMPLETE ENTIRE FORM IF NOT RELEASED TO FULL DUTY******

Can patient work an eight-hour day? ☐ YES ☐ NO – if not, how many hours per day, days per week? _____

Patient can:				
	Sit	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8 hours
	Stand	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8 hours
	Walk	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8 hours
	Drive	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8 hours

Other ☐ Please Explain: _____

Patient can use hands for repetitive:

Simple Grasping	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Fine Manipulation	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Keyboarding	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never

Other ☐ Please Explain: _____

Patient is able to:				
Bend / Lean	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Twist	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Squat	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Climb	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Crawl	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never
Reach Overhead	☐ No restriction	☐ Frequently	☐ Occasionally	☐ Never

Other ☐ Please Explain: _____

Patient can lift /carry: ☐ No restriction

10 pounds maximum (sedentary)	☐ Frequently	☐ Occasionally	☐ Never
Up to 20 pounds maximum (light)	☐ Frequently	☐ Occasionally	☐ Never
Up to 50 pounds maximum (medium)	☐ Frequently	☐ Occasionally	☐ Never
Over 50 pounds (heavy)	☐ Frequently	☐ Occasionally	☐ Never

Other ☐ Please Explain: _____

Push / Pull weight limitations: ☐ No restriction ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ OVER 50 lbs ☐ Other_____

Patient notified of functional limitations and release date: ☐ YES ☐ NO

In your estimation, restrictions are: ☐ Permanent ☐ Temporary until(please provide estimated date): _____

Current degree of disability as it pertains to the injury of this claim, and in accordance with NYS Workers' Compensation Medical Guidelines:

☐ None ☐ Mild (25%) ☐ Moderate (50%) ☐ Marked (75%) ☐ Total (100%)

Physician's Printed Name	**Physician's Signature**	**Date**

PLEASE FAX RESPONSE TO 585-235-6703. Phone 585-276-5136 for questions. THANK YOU.