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Statcare Urgent & Walk-In Medical Care

To Whom It May Concern:

_____ was seen and examined in our office on_____. After reviewing/discussing the patients job description and specific tasks. (S)he may return to work on _____ with the following instructions:

▢ The patient may return to work without restrictions
▢ The patient may return to work with the following restrictions
▢ Lifting greater than 5/10/20 lbs for a period of ___(days/weeks/ months)
▢ Repetitive arm motion for a period of ___(days/weeks/ months) ▢ Left arm ▢ Right arm ▢ Both arms
▢ Pushing/pulling greater than 5/10/20 lbs for a period of ___(days/weeks/ months)
▢ Standing greater than ___ hours per day for a period of ___(days/weeks/ months)
▢ Sitting greater than ___ hours per day for a period of ___(days/weeks/ months)
▢ Kneeling greater than___hours per day for a period of ___(days/weeks/ months)
▢ Other _____

If the above restrictions constitute modified duty, such that is not available, then it is assumed the employee will be sent home rather than return to work.

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My signature indicates that I have read and/or understood the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's ability to perform the job duties.

The patient's signature indicates they understand and agree to adhere to all of the restrictions listed above, and (s)he will notify his/her supervisor of any departure from these restrictions.

Sincerely,

_____ _____

_____ _____

Print Name
▢ MD ▢ PA ▢ NP

Print Name