

Employee's Name: **BAKENRA, KUBASA T**
M# 03323643
DOS: 9/18/2019

DOB: 6/05/1994
Age: 025Y Sex: M
A# 53197480014

to Work

DOB: 6/5/1994

To be completed by Physician:

After reviewing the patient's job description and the specific tasks within the job expectations please complete either (A) or (B) as appropriate, sign and date below.

(A) The above named employee has been released by the physician to return to work FULL DUTY with NO RESTRICTIONS as of 10/2/2019 (date)

(B) The above named employee had been released by the physician to return to work on _____ (date)
_____ (date)

<input type="checkbox"/> Lifting (max weight)	lbs.	<input type="checkbox"/> Sitting	hours per day
<input type="checkbox"/> Repetitive Lifting	lbs.	<input type="checkbox"/> Standing	hours per day
<input type="checkbox"/> Carrying	lbs.	<input type="checkbox"/> Walking	hours per day
<input type="checkbox"/> Pushing/Pulling	lbs.	<input type="checkbox"/> Squatting	hours per day
<input type="checkbox"/> Pinching/Gripping	lbs.	<input type="checkbox"/> Kneeling	hours per day
<input type="checkbox"/> Reaching over head	lbs.	<input type="checkbox"/> Crawling	hours per day
<input type="checkbox"/> Reaching away from body	lbs.	<input type="checkbox"/> Climbing	hours per day
<input type="checkbox"/> Other Restrictions: <div style="text-align: center; font-size: 2em;">RTW 10/2/19</div>			
<input type="checkbox"/> These Limitations/Restrictions Are:		<input type="checkbox"/> Temporary Limitations/Restrictions Are: <input type="checkbox"/> Permanent Limitations/Restrictions Are:	

IF THE ABOVE RESTRICTION(S) CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK. The patient may continue to follow up as needed for burn scar management.

Physician's Signature/Stamp: **Dr. Richard Grossman**

Date: 10/1/19