PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name: Kenneth Alfred	DOB: 10/3/62
Physician's Name: Jose Luis Gonzalez	Telephone #: 323-669-6453

To be completed by Physician

To whom it my concern,

The above named patient is a primary care patient of mine at Healthcare In Action Medical Group.

(A) The above named employee has been released by the above named physician to return to Full Duty as of 10/6/22 (Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) WITH THE FOLLOWING RESTRICTIONS:

Check applicable boxes and provide limitations/restrictions.	
☐ Lifting (Max weight in lbs) _____lbs.	☐ Walking _____hours per day
☐ Repetitive Lifting _____lbs.	☐ Standing _____hours per day
☐ Carrying _____lbs.	☐ Sitting _____hours per day
☐ Pushing/pulling _____lbs.	☐ Crawling _____hours per day
☐ Pinching/Gripping _____lbs.	☐ Kneeling _____hours per day
☐ Reaching over head	☐ Squatting _____hours per day
☐ Reaching away from body	☐ Climbing _____hours per day
☐ Repetitive Motion Restrictions:	
☐ Other Restrictions:	
These limitations/restrictions are:	☐ Temporary limitations/restrictions through _____. ☐ Permanent limitations/restrictions

My signature indicates that I have read and understand 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.

Physician's Name (Please Print): Jose Luis Gonzalez

Physician's Signature: [signature] Date: 10/5/22

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