

**RETURN TO WORK / ABILITY TO WORK RECOMMENDATION**

If injuries claimed by MANCON employees, please send this three-page form with the employee to the medical facility providing treatment.

Patient's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**TO BE COMPLETED BY TREATING/ATTENDING PHYSICIAN**

Brief Diagnosis / Condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I saw and/or treated this patient on \_\_\_\_\_ and based on the above description of the Patient's current medical problem:

Recommend his/her Return to Work with No Limitations on (date) \_\_\_\_\_

Patient may Return on (date) \_\_\_\_\_ with a Daily Time Limitation of \_\_\_\_\_ hours and/or Limitations specified hereinafter:

**PHYSICAL LIMITATIONS**

1. In an 8 hour work day, Patient may:

	<u>Not At All</u>	<u>Occasionally</u>	<u>Frequently</u>
A. Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Use Hands Repetitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Use Feet Repetitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Squat/Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Climb Steps/Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Reach/Stretch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FORWARD COPY WITHIN 24 HOURS OF INCIDENT TO MANCON® CORPORATE OFFICE  
 HUMAN RESOURCES ATTN: LAURA SIPES – FAX 757-457-9345 or EMAIL [LSIPES@MANCONINC.COM](mailto:LSIPES@MANCONINC.COM)**

**ENVIRONMENTAL LIMITATIONS**

2. In an 8 hour work day, Patient may:

	<u>Not At All</u>	<u>Occasionally</u>	<u>Frequently</u>
A. Temp. Above 100° F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Temp. Below 20° F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. High Humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Unventilated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poorly Lighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. High Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Overcrowded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Tight Restricting Areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ABILITY TO LIFT AND CARRY**

3. Check the category most appropriate for the Patient's current condition:

- Sedentary Work – Lift up to 10 pounds with occasional walking, standing, or carrying.
- Light Work – Lift up to 20 pounds with frequent walking, standing and carrying objects up to 10 pounds.
- Medium Work – Lift up to 30 pounds with frequency including walking, standing, and carrying same.
- Full Duty Work – Extended lifting and moving of material up to 50 pounds.

**OTHER INSTRUCTIONS AND/OR LIMITATIONS**

4. Respond as appropriate for the Patient's current condition:

A. List currently prescribed medications including name, dosage, periodicity, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

B. Is the Patient's diet a factor? \_\_\_\_\_

If so, describe dietary requirements \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

C. Could the Patient faint or otherwise lose consciousness at the workplace as the result of the current medical condition? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

D. Can the Patient's current condition cause significant risk to the health or safety of the Patient in the workplace?

\_\_\_\_\_  
 \_\_\_\_\_

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To others working with him/her? \_\_\_\_\_

If so, How can this risk be mitigated? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Does the Patient's current condition include any mental/emotional considerations which the employer should attempt to accommodate (Explain)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Additional Advice/Comments? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISPOSITION / ADVICE**

5.  Any restrictions or limitations herein are in effect until (date) \_\_\_\_\_ or until the Patient is re-evaluated on (date) \_\_\_\_\_.

Patient is not able to Return to Work at this time – Patient will be re-evaluated on (date) \_\_\_\_\_

Patient is being referred to \_\_\_\_\_ for purpose of \_\_\_\_\_

I will  will not  remain as Patient's Primary Physician of Record.

Medical Provider Name (Printed) \_\_\_\_\_ Medical Provider Signature \_\_\_\_\_ Date \_\_\_\_\_