Since 1983 mancon

1961 Diamond Springs Road
Virginia Beach, VA 23455
Phone: (888)892-0787 ext 312

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:

	Not At All	Occasionally	Frequently
A. Stand/Walk	☐	☐	☐
B. Sit	☐	☐	☐
C. Drive	☐	☐	☐
D. Use Hands Repetitively	☐	☐	☐
E. Use Feet Repetitively	☐	☐	☐
F. Bend/Stoop	☐	☐	☐
G. Twist	☐	☐	☐
H. Squat/Kneel	☐	☐	☐
I. Climb Steps/Ladders	☐	☐	☐
J. Reach/Stretch	☐	☐	☐

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

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ENVIRONMENTAL LIMITATIONS

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

	Not At All	Occasionally	Frequently
A. Temp. Above 100º F	☐	☐	☐
B. Temp. Below 20º F	☐	☐	☐
C. High Humidity	☐	☐	☐
D. Unventilated	☐	☐	☐
E. Poorly Lighted	☐	☐	☐
F. High Noise	☐	☐	☐
G. Overcrowded	☐	☐	☐
H. Tight Restricting Areas	☐	☐	☐

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 _____

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