

Work Release

Complete Integrative
Care Medford
3156 State St.
Medford, OR 97504
541.773.9772 (Ph)
541.773.1113 (Fx)



Complete Care Health
Centers Medford
3132 State St.
Medford, OR 97504
541.830.4352 (Ph)
541.826.2620 (Fx)

Complete Care Health
Centers Eagle Point
1296 S. Shasta Ave.
Eagle Point, OR 97524
(541) 830.4325 (Ph)
(541) 826.2620 (Fx)

Name of Worker: _____

Claim Number _____

1. Is the worker medically stationary? Yes No If Yes, date: _____ Next scheduled appt. date: _____
If No, estimated medically stationary date: _____ Are there permanent restrictions? Yes

No Unknown
Treatment Plan

2. Worker is released to:

- Full duty without limitations Date: _____ (Do not complete line 3 through 11. Sign below)
- Modified duty from (date): _____ through (date): _____ (Specify limitations below)
- Modified hours specify hours: _____ from (date): _____ through (date): _____
- Not released to work Est. RTW date: _____ If modified release, date of anticipated regular release: _____

Hours: No Limitations 1 2 3 4 5 6 7 8 Other (specify)

3. In a/an 8 10 12 other _____ hour workday, worker can stand/walk a total of _____
4. At time, worker can stand/walk _____
5. In a/an 8 10 12 other _____ hour workday, worker can sit a total of _____
6. at one time, worker can sit _____

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

| Pounds | <10 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | 65 | 70 | 75 | 80 | 85 | 90 | 95 | 100 | >100 | |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Occasionally | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. Worker can use hands for repetitive:

Right

Left

Dominant Hand

- a. Fine manipulation Yes No Yes No Right Left
- b. Pushing and pulling Yes No Yes No
- c. Simple grasping Yes No Yes No
- d. Keyboarding Yes No Yes No

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): Yes No

10. Worker is able to:

Continuous
67-100% of the day

Frequently
34-66% of the day

Occasionally
6-33% of the day

Intermittently
1-5% of the day

Not at all

- a. Stoop/bend _____
- b. Crouch _____
- c. Crawl _____
- d. Kneel _____
- e. Twist _____
- f. Climb _____
- g. Balance _____
- h. Reach _____
- i. Push/pull _____

11. Other functional limitations or modifications necessary in worker's employment:

| | | |
|--|---------------------|------------|
| Signature of medical service provider: _____ | Printed name: _____ | Date _____ |
|--|---------------------|------------|

I authorize Complete Care Health Centers to mail/fax a copy of Return To Work Information to my employer. Signature of

employee/patient _____ Date _____