WAUKESHA COUNTY
Health Care Provider Return to Work Form
HR-1500-J; HR-2600-A; RM-500-C

Dept of Administration
Waukesha County Administration Center
515 W. Moreland Blvd.
Waukesha, WI 53188
HR Phone: 262-548-7044
HR Fax: 262-896-8272
Risk Phone: 262-548-7852
Risk Fax: 262-548-7668

Waukesha County may consider a modified work assignment on a temporary basis. Classification and essential function specifications may be obtained by contacting the Human Resources Division at 262-548-7044 for personal illness/injury related matters or the Risk Management Division at 262-970-4716 for worker's compensation related matters.

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Please answer all questions relative to the patient as fully and completely as possible. There are questions that require answers about the frequency or duration of a condition or treatment; your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Please type or print legibly.

SECTION 1: GENERAL INFORMATION

Patient's Name: ______________________________________ Initial Date of Injury/Illness ______________________________

Appointment Date: ___________________________________

Appointment Time: ___________________________________ Departure Time: ____________________________

1. DIAGNOSIS/CONDITION (Provide the medical facts regarding the health condition which you are treating the patient for):

2. Based on the above description of the patient's health condition:

   a. In my opinion, this injury is work related: ☐ Yes ☐ No ☐ Unclear

OR

   b. The injury is an aggravation of a pre-existing condition: ☐ Yes ☐ No ☐ Unclear

3. The patient (check one of the following):

   ☐ May return to work on ____________________ (date) with no restrictions. (Proceed to Section 4).

   ☐ Unable to return to work at this time; will be re-evaluated on _____________________ (date). (Proceed to Section 4).

   ☐ May return to work on ____________________ (date) with the restrictions as indicated in Sections 2, 3 and/or 4 below.

SECTION 2: PHYSICAL CAPACITY

☐ This Section does not apply. (Proceed to Sections 3 & 4.)

OR

☐ The patient

1. May perform the following type of work:

   ☐ Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally, and other sedentary criteria are met.

   ☐ Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm/or leg controls.

   ☐ Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

   ☐ Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

   ☐ Light Heavy Work. Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

   ☐ Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

2. Within the patient's workday (typically 8 hours), the patient may:

Stand	1-2 hrs	2-4 hrs	4-6 hrs	Other ___
Walk	1-2 hrs	2-4 hrs	4-6 hrs	Other ___
Sit	1-2 hrs	2-4 hrs	4-6 hrs	Other ___
Drive	1-2 hrs	2-4 hrs	4-6 hrs	Other ___
Push	1-2 hrs	2-4 hrs	4-6 hrs	Other ___
Pull	1-2 hrs	2-4 hrs	4-6 hrs	Other ___

3. Patient may use hand(s) for:

Single Grasping	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___
Fine Manipulation	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___
Operating Controls	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___

4. Patient may use foot/feet for repetitive movement (e.g., operating foot controls):

☐ Never ☐ Seldom (1-10%) ☐ Occasionally (11-33%) ☐ Frequently (34-66%) ☐ Continuously (67-100%)

5. Patient may:

Bend	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Twist	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Squat	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Climb	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Run	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Kneel	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Crawl	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Reach	☐ Never	☐ 1-2 hrs	☐ 2-4 hrs	☐ 4-6 hrs	☐ 6-8 hrs	☐ Other ___	
Reach Rotation	☐ 0°	☐ 30°	☐ 60°	☐ 90°	☐ 120°	☐ 150°	☐ 180°
Reach Rotation	☐ Never	☐ Seldom (1-10%)	☐ Occasionally (11-33%)	☐ Frequently (34-66%)	☐ Continuously (67-100%)		

6. Other:

☐ No exposure to respiratory irritants; Explain: ___

☐ No exposure to skin irritants; Explain: ___

☐ Vision; Explain: ___

☐ Hearing; Explain: ___

☐ No exposure to temperature extremes (include range); Explain: ___

Detail any other instructions, medical facts or limitations related to the condition and/or that may interfere with work activity:

SECTION 3: PSYCHOLOGICAL/EMOTIONAL/BEHAVIORAL CAPACITY

☐ This Section does not apply. (Proceed to Section 4.)

OR

☐ The patient has limitations as noted below…

1.

A. Supervision Required:	**B. Supervision of Others:**	**C. Tolerance to Deadlines:**	**D. Attention to Detail:**
☐ Constant ☐ Frequent ☐ Limited ☐ No limitation	☐ Unable to supervise others or take any responsibility for their safety ☐ Can provide limited direction to others and take some responsibility for their safety ☐ Can provide direction to others and take responsibility for their safety with assistance or monitoring ☐ N/A or no limitation	☐ Cannot deal with deadlines ☐ Able to meet recurring deadlines ☐ Able to meet deadlines, with time management assistance ☐ No limitation	☐ Severely limited ☐ Limited ☐ Requires occasional breaks ☐ No limitation
E. Performance of Multiple Tasks:	**F. Concentration and Tolerance for External Stimulus:**	**G. Ability to Work with Others:**	**H. Ability to Cope with Confrontational Situations:**
☐ Can deal with one task at a time ☐ Can handle more than one, with cues ☐ Can handle more than one, with time management assistance ☐ No limitation	☐ Needs non-distracting work environment ☐ Can cope with small degree of distraction ☐ Can cope with distracting stimuli a portion of the day ☐ No limitation	☐ Has difficulty working effectively unless alone ☐ Tolerates others in vicinity, but requires independent tasks ☐ Can work with others cooperatively when required	☐ Unable to cope with confrontational situations ☐ Can cope when backup is available ☐ Moderate ability to cope with confrontational situation ☐ No limitation
I. Decision Making/ Judgement:	**J. Learning/Understanding and Memory:**	**K. Communication:**	**L. Adaptation:**
☐ Errors in judgement or indecision likely ☐ Has difficulty making decisions and/or may require support in decision-making tasks. ☐ Hesitates to make decisions or doesn't trust their own judgement ☐ No limitation	☐ Severely limited ☐ Limited but ability to perform tasks with guidance ☐ Moderate ability; easily recalls when prompted ☐ No limitation	☐ Unable to communicate effectively ☐ Able to communicate with familiar audiences in a limited capacity ☐ Able to communicate with familiar and unfamiliar audiences when required	☐ Unable to cope with change ☐ Able to cope with minor changes when provided notice in advance ☐ Able to cope with moderate change ☐ No limitation

2. For the above categories, include any clarifying comments; OR, detail any other instructions, medical facts or behavioral limitations related to the condition that may interfere with work activity.

3. Is the patient able to return to work without posing a significant risk or substantial harm to him/herself or others: ☐ Yes ☐ No

4. The patient will need follow-up treatment appointments and/or need to work part-time or on a reduced schedule due to the medical condition: ☐ Yes ☐ No

   a. The treatments or the reduced number of hours of work are medically necessary: ☐ Yes ☐ No

      i. If yes, estimate the treatment schedule, including dates of follow-up appointments and time required for each appointment, including any recovery period:

      ii. If part-time or reduced work schedule is required of the patient needs, please estimate:

         a) Hour(s) per day ____________

         b) Days per week ____

         c) From ___________________________ through __________________________

SECTION 4: OTHER INFORMATION

1. The patient has been prescribed medications: ☐ Yes ☐ No

   If yes, explain medication side effects: ____

   a. Will medication use limit or prohibit the patient from driving, operating heavy equipment, or performing any essential function of their position? ☐ Yes ☐ No

      If yes, please explain: ____

      ____

2. ☐ Restriction(s) identified in this document are in effect until I re-evaluate the patient on ___________________________ (date).

   The patient has been referred to: ☐ None ☐ ____ (provider or consultant name).

   ☐ Restriction(s) identified in this document are permanent.

3. If patient is in law enforcement (i.e., Deputy Sheriff), are they able to safely and effectively utilize a firearm? ☐ Yes ☐ No

By affixing my signature below, I certify that I am a licensed healthcare provider. I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

Name of Health Care Provider: _____________________________________ Type of Practice/ Medical Specialty: ____________________________

Health Care Provider Business Address: ____

Telephone Number: _____________________________________ Fax Number: _______________________________________

Signature of Health Care Provider: ____ Date: _______________________________

GINA Notification: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.