

**ATTENDING PHYSICIAN'S APPROVAL TO RETURN TO WORK**

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Employee: \_\_\_\_\_

Smith ID Number: \_\_\_\_\_

Current Position: \_\_\_\_\_

Department: \_\_\_\_\_

Please provide the following information, on the above-named employee so that we can determine his/her date of return to work. If you have any questions, please contact the Human Resources Office at (413) 585-2275, fax (413) 585-2284.

**Please return this completed form directly to your patient who will then return it to Human Resources, 30 Belmont Avenue, Northampton, MA 01063.**

This employee has my approval to return to work with no restrictions.

**Return to work date (no restrictions):** \_\_\_\_\_

This employee has my approval to return to work on \_\_\_\_\_  
with the following restrictions:

**Please Check Any Appropriate Box:**

- Work Restrictions:  2 hours/day  4 hours/day  6 hours/day  8 hours/day  > 8 hours/day
- Sitting Only  No Lifting  No Kneeling
- No exp. To dust/fumes, etc.  Sit/stand as needed  No Reaching
- Dry work only  Available for Overtime  No Bending
- Use of dominant hand/arm only  Use of non dominant hand/arm only  No Work
- No Driving
- Lifting up to:  10 lbs  11-15 lbs  16-25 lbs  26-40 lbs  >45 lbs

**Above restrictions are in place for** \_\_\_\_\_  Days  Weeks  Months

This employee is not yet medically able to return to work.

**Approximate date of return to work may be:** \_\_\_\_\_

**PHYSICIAN'S NAME** (please print): \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_

Date: \_\_\_\_\_