SMITH COLLEGE

**Office of Human Resources**
**30 Belmont Avenue**

# ATTENDING PHYSICIAN'S APPROVAL TO RETURN TO WORK

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 hr@smith.edu.

**Please fax this completed form to (413) 327-9107 or return 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.

☐ Other _____

**Above restrictions are in place for**_____☐ Days ☐ Weeks ☐ Months

Please list any other accommodations that may allow the employee to perform his/her job duties _____

_____

_____

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

**Approximate date of return to work:** _____

**PHYSICIAN'S NAME** (please print): _____

**PHYSICIAN'S SIGNATURE:** _____ Date: _____