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 (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

☐ 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: _____