University of Nebraska-Lincoln

Release to Work - Workability Form

This form is completed by a medical provider to help determine workability. The employee (patient) should provide a job description to the provider and is required to provide a copy of this completed form to their supervisor.

Patient Name Last: First: DOB:

Date of Injury or Illness: Date of Visit:

Check One: ☐ Initial Visit ☐ Follow-up ☐ Discharge from care

Treatment Plan:

Did the patient provide a copy of their job description and physical requirements for review? ☐ Yes ☐ No

Is this a worker's compensation claim? ☐ Yes ☐ No If Yes, what is the Diagnosis/Condition?

WORK STATUS (Choose One):

☐ **Full Duty**: May return to work on _____ with no restriction or limitations

☐ **No Duty Temporarily**: Unable to return to work as of _____

Anticipated return to work date _____ to ☐ Temporary Modified Duty ☐ Full Duty

☐ **Temporary Modified Duty:** May return to work on _____ with the following limitations (measured in hours)

These limitations are TEMPORARY and will be reassessed on: _____

	0	1	2	3	4	5	6	7	8	9	10	11	12
Total Hours Worked Per Day	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
General Physical Requirements													
Stand/Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bend/Stoop	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Squat/Crouch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kneel/Crawl	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Overhead Work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lifting and Carrying ☐ Left ☐ Right ☐ Both													
0 – 10 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10 – 20 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20 – 30 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30 – 50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
50 – 75 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
75 – 100 lbs.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hands: ☐ Left ☐ Right ☐ Both													
Grasping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pinching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pulling/Pushing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Keyboarding/typing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feet: ☐ Left ☐ Right ☐ Both													
Foot Controls/Pedal	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Not Listed:													
Describe:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Next office visit date: _____ Is the patient using medication that restricts the ability to drive or work safely? ☐Yes ☐ No

Expected to resume full duty within: ☐24 hrs ☐48 hrs ☐30 days ☐60 days ☐90 days ☐120 days ☐180 days ☐180+ days ☐TBD

Was the patient referred to a specialist? ☐ Yes ☐ No Name: _____

Provider Name: _____ Provider Signature: _____

Provider Phone Number: _____ Patient / Employee's Signature: _____

I understand that by signing this form, I agree to release a copy to my employer.