



# Employee Status and Return to Work Report

To be completed for personal non work-related illness/injury.

Employees given restrictions or taken off work by a medical professional must submit this form prior to resuming work.

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

- Able to return-to-work without restrictions effective \_\_\_\_\_
- Unable to perform any work effective \_\_\_\_\_ through \_\_\_\_\_
- Able to return-to-work with the following restrictions effective \_\_\_\_\_

## Restricted Activities

Legend: N=Never O=Occasional (< 2.5 hours/day) F=Frequently (2.5-5 hours/day) C=Continuously (> 5 hours/day)

- Gripping: – N O F C
  - Grasping: – N O F C
  - Pinching: – N O F C
  - Bending: – N O F C
  - Twisting: – N O F C
  - Kneeling: – N O F C
  - Squatting: – N O F C
  - Weight Bearing: – N O F C
  - Pushing: – N O F C
  - Pulling: – N O F C
  - Reaching: – N O F C -  may reach shoulder level only  
 may reach to waist level only
  - Lifting: – N O F C Unassisted max weight \_\_\_\_\_ lbs.
  - Climbing:
    - Stairs N O F C
    - Ladders N O F C
    - Equipment N O F C
  - Work Hours – restricted to \_\_\_\_\_ per \_\_\_\_\_
- Affected Part of Body:  Right  Left  Both  Upper  Lower

Additional Recommendations:

Next Appointment Date: \_\_\_\_\_ Appt Time: \_\_\_\_\_

These restrictions are:  Temporary  Permanent These restrictions expire on (date): \_\_\_\_\_

Authorized Medical Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Leave Admin: \_\_\_\_\_ Date: \_\_\_\_\_

### THIS SECTION BELOW IS TO BE REVIEWED BY VERMEER MANAGER WITH EMPLOYEE

**Restricted Work Employee:** I understand I am returning to work with restrictions and/or follow-up medical appointments as specified above. If these work restrictions or appointments change during my treatment, I understand it is my responsibility to notify my manager immediately. I further understand it is my responsibility to attend my appointments and stay within these restrictions **both** at work and outside of work and I will under no circumstances deviate from them. If I fail to attend my scheduled appointments or am found working outside of my restrictions, I understand that I am subject to corrective action, up to and including termination.

**Manager of Restricted Work Employee:** I understand I am responsible for ensuring the tasks assigned to the employee within the workplace adhere to the restrictions specified above. I will review the employee's medical restrictions and job duties with the employee at the start of each work week, or upon receiving a written change in the employee's restrictions.

We have reviewed the above and it is agreed the employee can perform the following work activities while adhering to the above restrictions:

- ALL WORK tasks (essential functions) that are required during a typical work week
- MODIFIED / ALTERNATE WORK modified duty has been assigned.
- NO WORK is available

Employee Signature: \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_

Manager Signature: \_\_\_\_\_ ID# \_\_\_\_\_ Date: \_\_\_\_\_

Return this Form to: MEDICAL LEAVE ADMIN: Phone: 641-621-7950 | Fax: 641-621-7722 | Email: [benefits@vermeer.com](mailto:benefits@vermeer.com)