ALABASTER
CITY SCHOOLS
CHAMPIONS OF OUR FUTURE

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	Date:
Physician's Name:	Telephone #:

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below. Please fax the completed form to Human Resources, (205) 663-8468.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _____ (Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) WITH THE FOLLOWING RESTRICTIONS through _____(Date):

Check applicable boxes and provide limitations/restrictions.	
† Lifting (Max weight in lbs) _____lbs.	† Walking _____ hours per day
† Repetitive Lifting _____lbs.	† Standing _____ hours per day
† Carrying _____lbs.	† Sitting _____ hours per day
† Pushing/pulling _____lbs.	† Crawling _____ hours per day
† Pinching/Gripping _____lbs.	† Kneeling _____ hours per day
† Reaching over head	† Squatting _____ hours per day
† Reaching away from body	† Climbing _____ hours per day
† Repetitive Motion Restrictions:	
† Other Restrictions:	
These limitations/restrictions are:	⑥ Temporary limitations/restrictions ⑥ Permanent limitations/restrictions

Physician's Name (Printed)			
Physician's Signature:		Date:	