

**DHHS/
Return to Work Recommendation – Worker’s Comp**

Employee Name _____ Date of Examination _____ Arrival Time _____

Medical facts regarding condition/injury, cause and prognosis _____

Treatment plan and current medications affecting job performance _____ **Work Related? Y N**

DATES UNABLE TO WORK: _____ **Hours per Day** _____

Maximum Weight Limitations Related to Injury/Condition (check all that apply)											
	10 lbs.	15 lbs.	20 lbs.	35 lbs.	50 lbs.	Not Limited		Comments			
Lift											
Carry											
Push/Pull											
Physical Limitations Related to Injury/Condition (check all that apply)											
Hours Performed Daily	Never	1-2	3-4	5-6	7-8	9-10	Unlimited	Comments			
Bending											
Climb											
Twist - Rotation - %											
Kneel											
Crawl											
Stand											
Walk											
Sit											
Reach Overhead											
Reach Forward											
Keyboard Use											
Operate Motor Vehicle											
Grip/Grasp - Left/Right											
Exposure Limitations Related to Injury/Condition (check all that apply)											
Cold	Heat	Water	Dampness	Oil	Fumes	Chemicals	Solvents	Paint	Coolants	Insecticide	Acid
Dates											
Above Restrictions End			Able to Return to Work			Next Evaluation			Maximum Medical Improvement		
Date			Date			Date			Yes /Date		

Attending Physician’s Signature _____ Printed Name _____ Date _____
 Phone # _____

Referred To: _____ Date _____

SEND ALL BILLS TO: FARA
 9140 West Dodge Rd, Suite 63:
 Omaha, NE 68114 Telephone (800) 576-8492; Fax (402) 393-0265

I acknowledge I received a copy of this form and am aware of the above limitations which are in effect 24 hours a day/7 days a week . I will provide a copy to my supervisor and the original to my Work Comp Contact.	
Employee Signature _____	Date _____