UNION STANDARD INSURANCE GROUP
a Berkley Company

RETURN TO WORK – MEDICAL RELEASE

Section I:

EMPLOYEE NAME: _____ SSN#: _____

Description of Injury: _____

PLEASE CHECK ONE OF THE FOLLOWING
Employee may return to work:

A._____ Without restrictions on _____
(Date)

B. _____ Less than full schedule, from the time period _____ to _____
(Indicate specific dates or span of time)
Number of hours per day _____, Release Date to Return Full Schedule: _____

C. _____ With these restrictions (list below), from the time period _____to _____
(indicate specific dates or span of time)
with Full Medical Release Effective: _____

RESTRICTIONS

If the employee's ability to perform any of the following activities is limited by his/her condition, please describe the extent of the limitation and the expected duration.

Restriction	Limitation	Expected Duration
Standing		
Walking		
Sitting		
Kneeling		
Crawling		
Climbing		
Lifting/Carrying/Weight Limitation		
Reaching/working overhead		
Pushing/Pulling		
Driving		
Keyboard use/Repetitive hand motion		

List any other restrictions or limitations not listed above (i.e. including any medication side effect implications):

Is there assistance that would enable employee to return to work? ____No ___ Yes. If yes, please explain:

Section II: SIGNATURE OF HEALTH CARE PROVIDER

SIGNATURE OF HEALTH CARE PROVIDER: _____ DATE: _____

NAME OF HEALTH CARE PROVIDER (please print):_____

OFFICE PHONE #_____ OFFICE FAX # _____