UNIVERSITY OF NOTRE DAME
OFFICE OF HUMAN RESOURCES

Return form at least 7 calendar days prior to your return to work to:
1) Your Supervisor
2) CareWorks Fax: (888) 436-9535

Return-to-Work/Work Release

Employee: _____ **NDID: 9**_____
Date Leave Began: ___/___/____ **Date of Birth:** ___/___/_____

☐ The employee is able to return to full, regular duty work on __/__/__.
☐ The employee can return to work with the restrictions stated below. The restrictions are for the period of __/__/__ through __/__/__.
These restrictions are ☐ temporary ☐ permanent.
☐ The employee is able to return to work on a reduced schedule for ____ hours per day from __/__/__ through __/__/__.
☐ The employee is unable to return to work until __/__/__.

Please complete only if the employee has restrictions

In an 8 hour workday, employee can: (Circle full hourly capacity for each activity). If more than 8 hours, please indicate below.

Sit	1	2	3	4	5	6	7	8	_____
Stand	1	2	3	4	5	6	7	8	_____
Walk	1	2	3	4	5	6	7	8	_____

Are there restrictions in:	Yes	No	Comments
Lifting/Carrying	☐	☐	_____
Use of hands in repetitive actions	☐	☐	_____
Use of feet in repetitive movements	☐	☐	_____
Bending	☐	☐	_____
Squatting	☐	☐	_____
Crawling	☐	☐	_____
Climbing	☐	☐	_____
Reaching above shoulder level	☐	☐	_____
Other (please specify)	☐	☐	_____

I examined_____ **on** __/__/__ and certify that the employee ☐ is able to return to full, regular duty work ☐ is not able to return to full, regular duty work without posing a significant risk of harm to the employee or others.

_____ _____
Health Care Provider Signature Date

Health Care Provider: Please complete the following and please print. ***Do not include any additional medical information.***

Health Care Provider Name: _____
Address: _____
City/State/Zip: _____/ _____/ _____
Phone Number: _____