RAMAPO COLLEGE OF NEW JERSEY

Physician Return to Work Authorization – Physical Health

Directions: To be completed by the employee's health care provider in anticipation of employees return to work from medical leave.
Submit to: Ramapo College of New Jersey – Benefits Office, fax: 201-684-7508

Employee Name | Date of Birth | Job Title

Doctor's Name | Next Scheduled Appointment

Body Part(s) Involved

☐ The patient may return to work on _____ ***without any limitations*** on Date

☐ The patient may return to work _____ ***with limitations*** on Date

☐ The patient can return to work ***Part-time*** _____ hours/weeks for _____ (duration)

If there are any limitations, ALL boxes below must be filled out.

Limitations (if applicable)		No Limitations	Frequent (3-5 hours)	Occasionally (1-3 hours)	Not at all
1. Patient May	**a. Sit**				
	b. Stand				
	c. walk				
	d. Use of (R/L) Hand (none/as tolerated)				
	e. Use of (R/L) Foot (none/as tolerated)				
2. Patient may lift:	**a. Sedentary to 10 lbs.**				
	b. Light 10-20 lbs.				
	c. Medium 20-50 lbs.				
	d. Heavy 50-100 lbs.				
	e. Very heavy 100+ lbs.				
3. Patient may carry:	**a. Light 0-10 lbs.**				
	b. Medium 10-25 lbs.				
	c. Heavy 25-50 lbs.				
	d. Very heavy 50+ lbs.				
4. Patient may:	**a. Push**				
	b. Pull				
	c. Twist				
	d. Climb				
	e. Balance				
	f. Stoop				
	g. Kneel				
	h. Crawl				
	i. Reach				
	j. Grasp				
5. Patient may perform repetitive movement					
6. Patient may drive:	**a. With clutch**				
	b. Without clutch				
	c. Heavy equipment				

Please explain further any of the limitations marked above. Are these limitations: ☐ Temporary ☐ Permanent
If temporary, for how long? _____

Specify any environmental requirements or assistive devices, e.g. crutches, sling, boot, cane, etc.

Signature of Doctor | Date | Phone Number

Address | Fax Number