
Attending Physician's Approval to Return to Work

Employee: _____ Smith ID#: _____

Position: _____ Department: _____

Please provide the following information on the above-named employee so that we can determine their date of return to work. If you have any questions, please contact the Leave Administrator at (413) 585-2260 or hrbenefits@smith.edu.

 This employee has my approval to return to work with no restrictions.

Return to work date: _____

 This employee has my approval to return to work on _____ with the following restrictions.**Please check any box that applies:****These restrictions are in place for** _____ Days Weeks Months Work Restrictions: 2 hours/day 4 hours/day 6 hours/day 8 hours/day >8 hours/day Unavailable for overtime Sitting work only Sit/stand as needed No driving No kneeling No bending No reaching No exposure to dust/fumes, etc. Dry work only Use of dominant hand/arm only Use of non-dominant hand/arm only Lifting up to: 10 lbs. 11-15 lbs. 16-25 lbs. 26-40 lbs. >45 lbs. Other: _____ This employee is not yet medically able to return to work.

Estimated date of return to work: _____

Please fax this completed form to (413) 585-2284 or return directly to your patient who will then return it to Human Resources at 42 West Street, Northampton, MA 01063.

Physician Name (print): _____**Physician Signature:** _____ **Date:** _____