Please complete and return this notice to your patient before s/he leaves your office.

BURBANK UNIFIED SCHOOL DISTRICT
HUMAN RESOURCE SERVICES
1900 WEST OLIVE AVENUE • BURBANK • CALIFORNIA • 91506
TELEPHONE (818) 729-4400 • FAX (818) 729-4554

CERTIFICATE FOR RETURN TO WORK OR FURTHER TREATMENT

Patient/Employee Name: _____ Job Title: _____

Industrial Injury Yes ☐ No ☐ Date of Injury/Disabling Condition: _____ Exam Date: _____

The above employee has been under my care since _____ (Date)

PATIENT'S STATUS

Please indicate **ALL** that apply.

☐ Job Analysis or Job Description has been reviewed and taken into consideration.

☐ Return to Work with **NO RESTRICTIONS** on _____ (Date) Follow up visit (if needed) _____ (Date)

☐ Return to Work **WITH RESTRICTIONS**** starting _____ (Date) thru _____ (Date)

☐ Employee is expected to **RETURN TO FULL DUTY WITHIN 60 DAYS** ☐ Restrictions are **PERMANENT**

☐ **TAKEN OFF WORK** starting _____ (Date) thru _____ (Date)

☐ Next Appointment Date: _____

****NOTE PHYSICAL RESTRICTIONS BELOW**

PHYSICAL ACTIVITY RESTRICTIONS

☐ NO repetitive lifting/carrying of _____lbs. or more
☐ NO lifting/carrying of _____lbs. or more
☐ NO repetitive pushing/pulling of _____lbs. or more
☐ NO pushing/pulling of _____ lbs. or more
☐ NO at or above shoulder level reaching
☐ NO repetitive keyboarding in excess of ____minutes per hour
☐ NO prolonged walking in excess of ____hours
☐ NO repetitive bending / stooping
☐ NO repetitive squatting / kneeling
☐ NO prolonged standing in excess of ____hours
☐ NO prolonged sitting in excess of ____hours
☐ Must alternate sitting/standing
☐ NO running / jumping / climbing
☐ Other: (please be specific) _____

Additional Physician Restrictions:

_____ _____
Physician's Original Signature Date

PLEASE PRINT:

Physician's Name:_____ CA Lic #:_____

Address_____

Phone_____ Fax: _____

RETURN FORM TO: Burbank Unified School District – Human Resources Services 05/09