



City of Gunnison

Dear Medical Professional:

City of Gunnison would like to assist in the transition to full duty work for employees suffering from either work or non-work related injury or illness. We are able to accommodate many restrictions you believe fit to ensure a full recovery. This includes, but is not limited to, modified hours, duties and flexibility to continue medical treatment.

Please complete the attached form, or your comparable version of this form, outlining any restrictions assigned to this employee. Please understand that the ultimate objective is a return to full duty employment, and we ask that you keep this in mind when establishing a treatment plan.

If our employee is unable to return to work immediately, please call the City of Gunnison Finance Department. Should you have any questions or need to review additional information, please contact us at 970-641- 8070.

Sincerely,

City of Gunnison



Return to Work Medical Evaluation Form

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient. Our goal is to return the injured or ill City of Gunnison employee to his or her full working capacity as soon as possible. Thank you for your assistance.

Please print

Employee's Name: _____ SS#: _____

Date of injury/surgery/onset of illness: _____ Date of exam: _____

Diagnosis or description of injury/surgery/illness: _____

The patient's return to work status is:	The patient's restrictions or limitations are:	The patient can perform them:		
		Frequently	Occasionally	Not at all
<input type="checkbox"/> Return to regular work Date: _____	<input type="checkbox"/> Lifting above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Able to return to work with noted restrictions Date: _____	<input type="checkbox"/> Lifting from below knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unable to return to work until next evaluation Date: _____	<input type="checkbox"/> Twisting of upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Referred to another health care provider Name: _____ Date: _____	<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Squatting, kneeling or crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Repetitive wrist movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Repetitive feet movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Operating industrial equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Driving company vehicle or tractor/trailer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Exposure to dust or fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Exposure to skin irritants, solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Must wear hearing protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Must wear eye protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Alternate sitting and standing every ___ hours			
	<input type="checkbox"/> Limit standing to ___ hours a day			
	<input type="checkbox"/> Limit daily work to ___ hours a day			
	<input type="checkbox"/> Under medication that could affect ability to work Please explain: _____			
Lifting restrictions				
<input type="checkbox"/> None				
<input type="checkbox"/> 40-50 lbs.				
<input type="checkbox"/> 30-39 lbs.				
<input type="checkbox"/> 20-29 lbs.				
<input type="checkbox"/> 10-19 lbs.				
<input type="checkbox"/> less than 10 lbs.				

Follow-up plan of treatment None Return visit on _____ at _____ a.m./p.m.

Additional comments: _____

Health care provider's signature

Health care provider's name (please print)

Date signed

Phone number (include area code)

Street address

City, State and Zip code