WASHINGTON STATE UNIVERSITY
WORK ASSESSMENT/RETURN TO WORK FORM

Please return form to: WSU Human Resource Services (HRS)
Office Location: 139 French Administration Building
OR Mailing Address: PO Box 641014
Pullman, WA 99163-1014
OR Fax: 509-335-1259
Questions? Call HRS at: 509-335-4521

Name of Patient/Employee (Last, First, MI) (please print)

RETURN TO WORK (select and complete all that apply)

☐ He/She is released to return to work **full-time** effective ___/____/_____ (date).

☐ He/She is released to return to work **part-time**, estimate the number of hour(s) per day_____, day(s) per week_____, from ___/____/_____ (date) through ___/____/_____ (date).

☐ He/She is totally incapacitated at this time. Patient will be reevaluated on ___/____/_____ (date).

Health Care Provider please complete as applicable based upon your clinical evaluation and testing results

DURATION OF RESTRICTIONS

The below restrictions are in effect until ___/____/____ (date) or until reevaluation on ____/____/____ (date)

PHYSICAL CAPACITIES

Mark or check (☑) full capacity for each activity in one shift (items you do not believe you can answer should be marked N/A)

A. Patient can	**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Continuous 67-100% (not restricted)**
Sit					
Stand (in place)					
Walk					
Perform work from a ladder					
Climb stairs					
Climb ladder					
Bend / Stoop					
Squat / Kneel					
Twist					
Crawl					

B. Patient can use side indicated: Left, Right, Both		**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Continuous 67-100% (not restricted)**
Reach	L, R, B					
Work above shoulders	L, R, B					
Wrist (flexion/extension)	L, R, B					
Grasp (forceful)	L, R, B					
Fine Manipulation	L, R, B					
Vibratory tasks, high impact	L, R, B					
Vibratory tasks, low impact	L, R, B					

C. Patient can lift	L, R, B	**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Continuous 67-100% (not restricted)**
0 to 10 lbs						
11 to 25 lbs						
26 to 50 lbs						
51 to 100 lbs						

D. Patient can carry	L, R, B	**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Continuous 67-100% (not restricted)**
0 to 10 lbs						
11 to 25 lbs						
26 to 50 lbs						
51 to 100 lbs						

E. Patient can push/pull	L, R, B	**Never**	**Seldom 1-10% 0-1 hour**	**Occasional 11-33% 1-3 hours**	**Frequent 34-66% 3-6 hours**	**Continuous 67-100% (not restricted)**
0 to 10 lbs						
11 to 25 lbs						
26 to 50 lbs						
51 to 100 lbs						

Employee Name (Last, First, MI)		
COGNITIVE/PSYCHOLOGICAL CAPACITIES		
Statement of psychological/cognitive diagnosis(es) *(include DSM-V diagnosis):*		
How often is patient receiving treatment from you and/or another health care provider for this condition?		
PLEASE IDENTIFY FUNCTIONAL LIMITATIONS OF DIAGNOSIS(ES):		
Patient has the ability to meet the cognitive demands of the job as described in the cognitive job analysis or job description. *(Select one)* ☐ Cognitive Job Analysis ☐ Job description ☐ Job as described by the employee		☐Yes ☐No
Patient has the ability to meet the psychological demands of the job as described by the cognitive job analysis or job description. *(Select one)* ☐ Cognitive Job Analysis ☐ Job description ☐ Job as described by the employee		☐Yes ☐No
Patient has the ability to multitask without significant loss of efficiency or accuracy. This includes the ability to perform multiple duties from multiple sources.		☐Yes ☐No
Patient has ability to work and sustain attention with distractions and/or interruptions.		☐Yes ☐No
Patient is able to interact appropriately with a variety of individuals including customers/clients.		☐Yes ☐No
Patient is able to deal with people under challenging circumstances.		☐Yes ☐No
Patient has the ability to work as an integral part of a team. Includes ability to maintain workplace relationships.		☐Yes ☐No
Patient is able to maintain regular attendance and be punctual.		☐Yes ☐No
Patient is able to understand, remember and follow verbal and written instructions:	Simple Instructions Detailed Instructions	☐Yes ☐No ☐Yes ☐No
Patient is able to complete assigned tasks with minimal or no supervision.		☐Yes ☐No
Patient is able to exercise independent judgment and make decisions.		☐Yes ☐No
Patient is able to perform under stress and/or in emergencies.		☐Yes ☐No
Patient is able to perform in situations requiring meeting deadlines.		☐Yes ☐No
Patient is able to perform in situations requiring speed or productivity quotas.		☐Yes ☐No
Clarify or add any additional information here:		
OTHER RESTRICTIONS AND EFFECTS OF MEDICATION		
If there are other job restrictions you have not described elsewhere, please describe here:		
Is patient currently prescribed medication that would impair job function? If so, please indicate above or describe:		
CERTIFICATION OF MEDICAL NECESSITY		
Are all listed work restrictions medically necessary? ☐Yes ☐No		

HEALTH CARE PROVIDER INFORMATION		
I certify that the information provided on this form is true and correct to the best of my knowledge.		
Name of Health Care Provider *(please print or type)*	Health Care Provider Signature	Date
Health Care Provider Street Address	City, State, Zip	
Type of Practice	Telephone	Fax

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services".

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