



RETURN TO WORK FORM

Medical Authorization and Attending Physicians Report

ABC of Alaska, PLEASE COMPLETE

Name of Apprentice/Patient:	Last	First
Date of Injury/illness request for internal suspension	Last 4 of Social Security Number	
Name of Employer/Company		
Employer Authorization	Doctor to be seen	

Employer: Please list work that may be available, in accordance with the physical restrictions indicated below.

Sedentary	Light	Medium	Heavy

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

_____ has been treated today for

In accordance with this patient's physical capability, check all that apply

- May resume work immediately, no restrictions
- May resume work immediately with the following restrictions
 - Sedentary work (sitting, occasional walking, standing, lifting less than 10lbs.)
 - Light work (lifting less than 20lbs.)
 - Medium work (lifting less than 50lbs.)
 - Heavy work (lifting less than 100lbs.)

He/She is released to work

- _____ hrs. per work day
- His/ her normal shift
- He/she may return to work at full duty on (date) _____
- He/ She has a return appointment on(date) _____ at _____

Physician's Signature

Date

Physicians Name (type or print)

DISTRIBUTION INSTRUCTIONS:

This form must be returned to ABC of Alaska the same day as treatment. Distribute copies as follows:

Original: ABC of Alaska Copies: Apprentice File & Employer (if applicable)