Return to Work Authorization

University of Central Oklahoma

Must be completed and returned to HR office before Employee can return to work.

Employee Name:_____ UCO Banner ID: #_____

Department:_____ Campus Box #_____

Supervisor's Name:_____

I have taken into consideration the job description and this patient may return to:

_____Regular Duty as of _____

_____Modified Duty as of _____ **with** the following restrictions:

_____No Repetitive Gripping
_____No Repetitive Bending/Twisting
_____No Repetitive Lifting
_____No Pushing/Pulling/Reaching
_____No Lifting above the shoulder level
_____Limited Walking/Running/Jumping
_____No Driving Motor Vehicles
_____No Repetitive Turning/Stooping
_____Weight Limit_____lbs.
_____Other, please specify:

_____Awkward Position
_____No Dust/Mold/Fumes/Smoke/Gases
_____Limited Exposure to Extreme Heat/Cold
_____No Exposure to Chemicals
_____No lifting above the waist level
_____No Squatting/Crawling/Kneeling
_____No Climbing
_____Limited Sitting/Standing
_____Limited Carrying/Holding

_____ _____
Examining Physician Name (Please Print) Phone Number

_____ _____
Physician Signature Date

Return to Human Resources, Benefits Coordinator, Box 171