Modified Duty and Return to Work Form

(Do not use for shift Firefighters.)

_____ (patient/employee name) was evaluated on _____ (date).

*Complete section (a) below if the employee does **not** have restrictions*

(a) Return to full activities at work **without** restrictions on _____ (date).

*Complete section (b) below if the employee **does** have restrictions.*

(b) Return to work on _____ (date) to perform modified work and ***cannot*** do one or more of the below activities. Duration of restrictions: _____.

☐ Stand for more than ____ hours per day.
☐ Sit for more than ____ hours per day.
☐ Kneel/squat for more than ____ hours per day.
☐ Bend/stoop for more than ____ hours per day.
☐ Push/pull for more than ____ hours per day.
☐ Twist for more than ____ hours per day.
☐ Walk for more than ____ hours per day.
☐ Climb stairs/ladders for more than ____ hours per day.
☐ Grasp/squeeze for more than ____ hours per day.
☐ Holster/carry/discharge a firearm.
☐ Flex/extend for more than ____ hours per day.
☐ Reach for more than ____ hours per day.
☐ Reach overhead for more than ____ hours per day.
☐ Type/keyboard for more than ____ hours per day.
☐ Lift/carry objects for more than ____ hours per day.
☐ Work for more than ____ hours per day.
☐ Drive a vehicle for more than ____ hours per day.
☐ Operate heavy equipment for more than ____ hours per day.

Other restrictions: _____

This individual is to return for further evaluation on _____ (date/no. of weeks).

Health Care Provider Information

Provider Name (print): _____

Telephone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Signature of Health Care Provider: _____ Date: _____

Providers: Employee Job Descriptions are available at
https://www.governmentjobs.com/careers/friscotexas/classspecs

Return the completed form to your supervisor and Human Resources (benefits@friscotexas.gov or fax to 972.292.5229). For questions, contact Human Resources at 972.292.5204.