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

P.O. Box 239 201 W. Virginia Avenue Gunnison, CO 81230-0239 PHONE: (970) 641-8000 FAX: (970) 641-8051

# 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:**

- ☐ Return to regular work
  Date: _____
- ☐ Able to return to work with noted restrictions
  Date: _____
- ☐ Unable to return to work until next evaluation
  Date: _____
- ☐ Referred to another health care provider
  Name: _____
  Date: _____

**Lifting restrictions**

- ☐ None
- ☐ 40-50 lbs.
- ☐ 30-39 lbs.
- ☐ 20-29 lbs.
- ☐ 10-19 lbs.
- ☐ less than 10 lbs.

**The patient's restrictions or limitations are:**

| | The patient can perform them: Frequently | Occasionally | Not at all |
|---|---|---|---|
| ☐ Lifting above shoulders | ☐ | ☐ | ☐ |
| ☐ Lifting from below knees | ☐ | ☐ | ☐ |
| ☐ Twisting of upper body | ☐ | ☐ | ☐ |
| ☐ Climbing | ☐ | ☐ | ☐ |
| ☐ Squatting, kneeling or crawling | ☐ | ☐ | ☐ |
| ☐ Repetitive wrist movement | ☐ | ☐ | ☐ |
| ☐ Repetitive feet movement | ☐ | ☐ | ☐ |
| ☐ Operating industrial equipment | ☐ | ☐ | ☐ |
| ☐ Driving company vehicle or tractor/trailer | ☐ | ☐ | ☐ |
| ☐ Exposure to dust or fames | ☐ | ☐ | ☐ |
| ☐ Exposure to skin irritants, solvents | ☐ | ☐ | ☐ |
| ☐ Must wear hearing protection | ☐ | ☐ | ☐ |
| ☐ Must wear eye protection | ☐ | ☐ | ☐ |

- ☐ Alternate sitting and standing every ___ hours
- ☐ Limit standing to ___ hours a day
- ☐ Limit daily work to ___ hours a day
- ☐ Under medication that could affect ability to work
  Please explain: _____

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

**Return this completed form to: City of Gunnison Finance Department, PO Box 239, 201 W. Virginia Ave., Gunnison, CO 81230**
**Phone: 970-641-8070 Fax: 970-641-8051**