MONTGOMERY COUNTY SHERIFF'S OFFICE
#1 CRIMINAL JUSTICE DR. ★ CONROE, TX 77301
SHERIFF RAND HENDERSON
CONROE: 936★760★5871

LIGHT DUTY REQUEST
NON-WORK RELATED INJURY/ILLNESS

This form is to be completed by the physician or authorized designee

PART I: GENERAL INFORMATION	
Date:	Clinic/Facility Name:
Employee Name:	Clinic/Facility Address:
Date of Visit:	City: State: Zip:
Physician Name:	Clinic/Facility Phone:

PART II: WORK STATUS INFORMATION
The injured employee's medical condition:
☐ will allow the employee to return to work as of _____ (date) **without restrictions**.
☐ will allow the employee to return to work as of _____ (date) **with the restrictions** identified in Part III, which are expected to last through _____ (date).

PART III: ACTIVITY RESTRICTIONS																					
POSTURE RESTRICTIONS (if any)						MOTION RESTRICTIONS (if any)						MISC. RESTRICTIONS (if any)									
Max Hours Per Day	0	2	4	6	8	Max Hours Per Day	0	2	4	6	8	☐ Max hours per day of work: _____									
Standing	☐	☐	☐	☐	☐	Walking	☐	☐	☐	☐	☐	☐ Sit/Stretch breaks of _____ per _____									
Sitting	☐	☐	☐	☐	☐	Climbing stairs/ladders	☐	☐	☐	☐	☐	☐ Must wear splint/cast at work									
Kneeling/Squatting	☐	☐	☐	☐	☐	Grasping/Squeezing	☐	☐	☐	☐	☐	☐ Must use crutches at all times									
Bending/Stooping	☐	☐	☐	☐	☐	Wrist flexion/extension	☐	☐	☐	☐	☐	☐ No driving/operating heavy equipment									
Pushing/Pulling	☐	☐	☐	☐	☐	Reaching	☐	☐	☐	☐	☐	☐ No running									
Twisting	☐	☐	☐	☐	☐	Overhead Reaching	☐	☐	☐	☐	☐	☐ Dressing changes necessary at work									
Restrictions Specific to: (if applicable) ☐ Left Hand/Wrist ☐ Left Leg ☐ Right Hand/Wrist ☐ Right Leg ☐ Left Arm ☐ Back ☐ Right Arm ☐ Left Foot/Ankle ☐ Neck ☐ Right Foot/Ankle						Lift/Carry Restrictions (if any): ☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day. ☐ May not perform any lifting/carrying. Other: _____						Medication Restrictions (if any): ☐ Must take prescription medication(s) ☐ Advised to take over-the-counter meds ☐ Medication may make drowsy (possible safety/driving issues)									

PART IV: Treatment/Follow-Up Appointment Information:
☐ Evaluation by the treating doctor on _____ (date) at _____ am/pm.
☐ Referral to/consult with _____.
☐ None. This is the last scheduled visit for this problem. No further medical care is anticipated.

Physician's Signature:_____