Inspire ★ Challenge ★ Empower

ATTENTION: Treating Healthcare Professional for ___________________________________
(Name of injured Employee)

This is to notify you that the Middleton-Cross Plains Area School District has a *"Transitional Duty"* return to work program for employees with injuries resulting from job-related accidents. Enclosed is a blank Return to Work Release/Physical Capabilities Form.

Please complete the attached Return to Work Release/Physical Capabilities Form and return it to the school district with the employee or fax to (608) 836-3571, Attention Benefits, after they have received treatment and you have had a chance to develop a recovery plan. This will help us finding modified duty work within the limitations and capabilities you have recommended as a result of the employee's work-related injury. We would be happy to supply you with a formal job description, if you need additional information regarding the injured employee's physical requirements to perform their normal duties.

Please feel free to contact Tabatha Gundrum at (608) 829-9043 if you have any questions about the District's Return to Work program. **Please note that our Worker's Compensation Insurance carrier is United Heartland Insurance (P.O. Box 3026, Milwaukee, WI 53201-3026 – claims fax 262-787-7701).** We can provide you with the name and number of our claims case manager if needed. Thank you very much for your cooperation! We look forward to working with you in helping us promote a smooth recovery and transition back to work.

Sincerely,

Tabatha Gundrum
Director of Employee Services
tgundrum@mcpasd.k12.wi.us
(608) 829-9043

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Return to Work Release/Physical Capabilities Form

(To be completed by the employee's Physician or Treating Provider)

Employee Name: ______________________________ Evaluation Date: __________

If treating for a work-related injury: Date of Injury ______________

Part(s) of body affected ______________________________ Right ☐ Left ☐

The above-referenced employee has been evaluated and may return to:

Regular work on: ______________ (Date) **OR** Modified work on: ______________ (Date)

OR

Is not released, anticipated release date: ______________________________

ITEM	PERCENT OF DAY (Based on 8 hour day)					Restrictions And Recommendations
	0 Never	1-5 Rare	6-33 Occasionally	34-66 Frequently	67-100 Constantly	
Lifting (lbs)						
Floor to Waist Lift						
Waist to Shoulder Lift						
Horizontal Lift						
Bilateral Push force						
Bilateral Pull force						
Two hand carry						
Left hand carry						
Right hand carry						
Standing Tolerance						
Sitting Tolerance						

Note other specific restrictions: (example: repetitive motion, reaching, grasping, dry environment, etc.)

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____

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These restrictions are: ☐ Permanent ☐ Temporary, expected to last ______________ weeks.

Next appointment date: ______________________________

____

(Health Care Provider's Signature) (Please print Examiner's Name)

Physician's contact information: ______________________________

Practice name and address Phone, Fax