MONTANA MENTAL HEALTH NURSING CARE CENTER
Return to Work Recommendations

Dear Doctor:

Our employees are very important to us. We want them to return to work within their functional capacities as soon as they can. Please help us by providing the following information at each appointment. If you need additional information about the job duties, please call the employee's supervisor at 538-7451.

Upon completion of this form, please provide the employee with a copy so they may return it to our office and forward a copy to the Montana State Fund, P.O. Box 4759, Helena, MT. 59604-4759.

To be completed by physician:

Patient:_____

(1) Patient may resume full duties on_____.
(2) Patient may resume modified duties on_____ with these restrictions.

Patient can lift: up to _____ lbs. _____ up to 25 lbs.

_____ up to 50 lbs _____ over 50 lbs

Lifting can be performed during the work period:

_____ Occasionally _____ Frequently _____ Continuously

Patient is able to:

Sit	_____Frequently	_____Occasionally	_____Not at all
Stand	_____Frequently	_____Occasionally	_____Not al all
Walk	_____Frequently	_____Occasionally	_____Not at all
Bend	_____Frequently	_____Occasionally	_____Not at all
Twist	_____Frequently	_____Occasionally	_____Not at all
Stoop	_____Frequently	_____Occasionally	_____Not at all

Other restrictions:
_____
_____
_____

(3) Any treatment and/or medication that might affect patient when returning to work?
Yes_____ No_____
(4) Duration of limitations indicated above:_____
(5) Next appointment_____
(6) Physician's signature: _____ Date:_____
Physician's phone number: _____