Manchester Public Schools
Office of Human Capital & Talent Development
Benefits Office
45 North School Street
Manchester, Connecticut 06042
Tel: (860) 647-3458 / Confidential Fax: (860) 647-4551

DOCTOR'S DISABILITY RELEASE FORM

EMPLOYEE

Name of Employee (Please Print or Type):

Employee's Occupation/Job Title:

HEALTH CARE PROVIDER

THE FOLLOWING MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES PRIOR TO YOUR RETURN TO WORK.
PLEASE DO NOT RETURN TO WORK UNTIL YOU RECEIVE CLEARANCE FROM HUMAN RESOURCES.

Date of Visit:

Diagnosis/Condition:

Return to Full Duty (No Restrictions)

On: ______________________

Return to Restricted Duty

On: ______________________ *To:* ______________________

~ Please Indicate Restrictions Below ~

Squatting: *Yes / No / Minimal*
Crawling: *Yes / No / Minimal*
Kneeling: *Yes / No / Minimal*
Bending/Twisting: *Yes / No / Minimal*
Climbing: *Yes / No / Minimal*
Walking: *Yes / No / Minimal*
Sitting: *Yes / No / Minimal*

Overhead Lifting: □ *Left* □ *Right; Not > __ Lbs.*
Reaching: □ *Left* □ *Right; Not > ___ Lbs.*
Pushing: □ *Left* □ *Right; Not > __ Lbs.*
Pulling: □ *Left* □ *Right; Not > __ Lbs.*
Lifting Weight: □ *Left* □ *Right; Not > ___ Lbs.*
Repetitive Grasping: □ *Left* □ *Right; Not > __ Lbs.*
No Repetitive Use of: □ *Left* □ *Right* __________

Other *(Please Describe)*: ____

Name of Health Care Provider:

Specialty:

Address:

City: State: Zip:

Telephone Number:

Signature of Health Care Provider: *Date:*