Bluefield State College
Medical Return to Work Form

Please return completed form to:
Office of Human Resources, Bluefield State College
219 Rock Street, Bluefield, WV 24701
Phone: (304) 327-4013 Fax: (304) 327-4321

PHYSICIAN TO COMPLETE

Patient Name (BSC Employee):	
Diagnosis:	
Maternity Delivery Date (If applicable):	Date of Appointment:
Prognosis:	

Indicate number of visits, general nature and duration of treatment and medications. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or work less than the employee's normal work schedule. _____

_____

Please provide the following information related to this injury/illness. This will assist us in returning our employee to work.

1. ☐ Employee is released to return to normal work duties with **no restrictions** on _____ (date). If so, skip to signature section below. **OR**
2. ☐ Employee is totally incapacitated at this time: From: _____ To: _____ **OR**
3. ☐ Employee is released to return to work with the following **restrictions :**

   These restrictions are: ☐ **Permanent** ☐ **Temporary** If temporary, restrictions end _____ (date).

   Hours/Day: ☐ 7.5 hours ☐ 4 hours ☐ other _____

   Days/Week: ☐ 5 days ☐ 4 days ☐ 3 days ☐ other _____

   Lifting: ☐ 50 + lbs. ☐ 50 lbs. ☐ 20 lbs. ☐ 10 lbs. ☐ Other_____

   Other limitations: ☐ Stooping ☐ Bending ☐ Overhead Reaching ☐ Walking ☐ Sitting ☐ Standing ☐ Other _____

   Please provide any additional information: _____

   _____

   Employee may return to work and resume regular work duties on _____ (date); **OR** employee will be re-evaluated on _____ (date).

I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. Bluefield State College will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether the accommodation can be met in a reasonable fashion.

_____ _____
Physician's Signature Date

_____ _____
Name of Physician (please print) Physician's Phone

Physician's Office Name and Mailing Address: _____

_____