## RETURN TO WORK PLAN.
Please specify restrictions as needed.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th></th>
</tr>
</thead>
</table>

- Return to work Unrestricted on Effective Date ________________
- Return to work Restricted on Effective Date ________________
  - Expiration Date __________________________
  - Target Date for Full Recovery _______________________
  - Has the employee reached Maximum Medical Improvement (MMI)?
    - Yes
    - No
  - Target Date for MMI ____________________________

### LIFTING LIMIT OF _________________ POUNDS

- Limit work about chest/shoulder level with Upper Extremity
  - None
  - Limited to______

- Forceful or Repetitive Grasping with Hand
  - None
  - Limited to______

- Bending or Twisting at Waist
  - None
  - Limited to______

- Kneeling/Squatting
  - None
  - Limited to______

- Walking
  - None
  - Limited to______

- Seat or Stand at Will
  - Other ________________

- Limit Hours of Work to______________

### Additional Comments:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

## HEALTH CARE PROVIDER INFORMATION.

<table>
<thead>
<tr>
<th>Health Care Provider Name (please print)</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider’s Address</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Health Care Provider’s Signature</td>
<td>Date Signed</td>
</tr>
</tbody>
</table>

Form # HRLOA 6
Date Revised : 12/05/05