EMORY
HEALTHCARE

Medical Leave Update and Return to Work Status

Please fax completed form to 404-686-5942 or email ehccentralizedleaveoffice@emoryhealthcare.org

Employee/Patient: _____Date: _____

Date of Birth: _____Employee ID #: _____

Department Manager: _____ Department: _____

☐ **Will be re-evaluated for return to work status: _____**
Date

☐ **Return to regular duty without restrictions on (date): _____**

If the employee can return-to-work, but with physical limitations, indicate restrictions below.

☐ **Return to limited duty on (date): _____**

No lifting greater than: _____lbs.

No pushing/pulling greater than: _____lbs.

No prolonged sitting/standing/walking for more than: _____minutes per hour.

No prolonged/repeated bending/twisting at waist: _____ times per hour

No Prolonged/repeated kneeling/squatting: _____times per hour

Indicate any restrictions on the employee's schedule OR duration of restrictions above.

Employee limited to working: _____ hrs./day _____ days/week

These restrictions are in place for: _____day(s) _____month(s)

Other Restrictions: _____

_____

_____

Physician/Other Licensed Clinician (please print): _____

Phone: _____

Signature _____Date: _____