Banner Health®

Short Term Disability Return to Work Provider Authorization Form

Employee Instructions:

- ❒ Take this form to your provider.
- ❒ If provider releases you to work with or without restrictions take the completed form to Occupational Health.

Date: _____

Employee Name:	**Employee ID#:**

Provider Instructions:

- ❒ Complete the form and give back to the employee
  a. *If necessary, a list of the essential functions of the employee's position can be provided upon request.*

Based upon your patient's most recent examination, please note the following medical recommendations:

❒ Employee is fit to return to work ***with no restrictions*** effective on: _____/_____/_____

❒ Employee is fit to return to work ***with the following restrictions*** effective starting on:

_____/_____/_____ and ending on: _____/_____/_____ *(anticipated duration of restrictions)*,

With the following restrictions:

- ❒ Lifting (Max weight in lbs.) _____ lbs.
- ❒ Pushing/Pulling: _____ lbs.
- ❒ Standing: _____ hours per day / per week
- ❒ Sitting: _____ hours per day / per week

Briefly explain the physical restriction if not described above : _____

_____

_____

Duration: Maximum hours per day _____ Days or hours per week: _____

Return for Re-check: _____/_____/_____

Provider's Name (please print): _____

Provider's Signature: _____ Date: _____