FMC AIRPORT SERVICES
RETURN TO WORK

Medical Treatment Report

Employee Name: ____

Dates of Care: From: _____________ **To:** ____________

Diagnosis: ____

____

Disposition **(Please mark appropriate status):**

____ **Return To Modified Duty** **Date:** ____________

____ **Days Per Week** ____ **Hours Per Day**

____ **Return To Regular Duty** **Date:** ____________

____ **Return For Medical Check** **Date:** ____________

____ **Released From Physicians Care** **Date:** ____________

Work Restrictions	**Temporary**	**Permanent**
No Lifting Over _____ **Lbs.**		
Pushing or Pulling (Circle % - 0 10 30 50 80)		
Twisting or Bending Back (Circle % - 0 10 30 50 80)		
Working Above Shoulder Level (Circle % - 0 10 30 50 80)		
Kneeling or Squatting (Circle % - 0 10 30 50 80)		

No Use Of: __________________________________

No Repetitive Motion Of: _______________________

Medications: ________________________________

Other: _____________________________________

Physician's Signature: _____________________________ **Date:** _____________

Manager's Signature: ______________________________ **Date:** _____________

Note To The Employee: FMC Airport Services is committed to providing a safe working environment for its employees. We expect that you will comply with your physician's restrictions without exception. If you feel that you are being asked to do more than is indicated by your physician, please contact the Human Resource department at extension 36330. We will work with your supervisor to make sure your restrictions are complied with.