



Navajo Nation Workers' Compensation Program Release to Return to Work

Phone: 928-871-6389

Fax: 928-871-6083

Email: wcp@navajo-nsn.gov

P.O. Box 2489 Window Rock, AZ 86515

Client's Name: _____ DOB: _____ SSN: _____

Date of Injury: _____ Claim Number: _____

Hospital/Clinic: _____ Date of Visit: _____

Diagnosis: _____

Contributing Factors (If any): _____

Prognosis: _____

Any probably permanent results? Yes No

(Please check appropriate box enter appropriate date)

Had the patient reached maximum therapeutic benefit yet? Yes No If not, when? _____

The patient has been examined and is able to return to work on _____ (Date).

Due to the injury/occupational disease, the patient is unable to return to work;

From: _____ To: _____ (Date).

The patient is able to return to work, but must perform only restricted duties;

From: _____ To: _____ (Date).

Restriction included: _____

Lifting

- 00-10 lbs.
- 11-25 lbs.
- 26-50 lbs.
- 51 and over lbs.

Walking

- None
- 1-4 Hrs
- 4-6 Hrs
- _____

Bending

- None
- Occasionally
- Frequently
- _____

Carrying

- None
- Occasionally
- Frequently
- _____

Driving

- None
- 1-4 Hrs
- 4-6 Hrs
- _____

Return visit required on _____ (Date) at _____ AM/PM.

I certify that the above information reflects my professional opinion

Physician's Name (Print Name)

Physician's Signature (Date)