



**JOHNS HOPKINS**  
MEDICINE

Occupational Health Services  
98 N Broadway – Suite 421 / Baltimore, MD 21231  
Phone: 410-955-6211 / Fax: 410-955-1617

**Dear Medical Provider:**

**This restriction form is required if the employee has work-related restrictions. Please indicate the diagnosis and restrictions of activity or function with that diagnosis.**

**EMPLOYEE'S NAME:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_ **ICDA ORDSM III-R CODE#:** \_\_\_\_\_

**AFFILIATION:**     JHH     JHU     JHCP     JHHS     OTHER

**1. Return to duty date:** \_\_\_\_\_     Full Duty     With the following restrictions (see below)

**2.**

Maximum Allowable percent of work day (based on 8 hour shift) <b>ACTIVITY</b>	<b>100%</b> (full duty/no restrictions)	<b>75%</b> (45 minutes per hour or total of 6 hours/shift performing restricted duty)	<b>50%</b> (30 minutes per hour of total of 4 hours/shift performing restricted duty)	<b>25%</b> (15 minutes per hour or total of 2 hours/shift performing restricted duty)	<b>0%</b> (no activity, no use)
<b>Standing</b>					
<b>Walking</b>					
<b>Sitting</b>					
<b>Bending</b>					
<b>Upper Extremity</b> *R, L, Both					
<b>Hand, Wrist</b> *R, L, Both					
<b>Lower Extremity</b> *R, L, Both					

\*Circle One

**3. LIFTING:**(write pound limitation if indicated; may include horizontal, vertical, overhead, etc.) \_\_\_\_\_ **LB. PUSH/PULL** \_\_\_\_\_ **LB.**

**4. Comments or other limitations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. These restrictions will take effect on** \_\_\_\_\_ **and remain in effect for** \_\_\_\_\_ **week(s).**

**Signature of Physician:** \_\_\_\_\_

**Print name of Physician:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please return this form to:** Occupational Health Services/ 98 N Broadway – Suite 421 / Baltimore, MD 21231  
OR Fax to 410-955-1617

<b>FOR OHS OFFICE USE ONLY:</b>
<input type="checkbox"/> Pre-Employment <input type="checkbox"/> RTW <b>NURSE INITIALS:</b> _____