

County of Gloucester  
Human Resources Manual

<b>CHAPTER:</b>	<b>6 - LEAVE TIME</b>	<b>ADOPTED: 4/4/07</b>
<b>SECTION:</b>	<b>4 - SICK LEAVE</b>	<b>REVISED: 2/2/11</b>

**EXHIBIT K – MEDICAL RELEASE FORM**  
**County of Gloucester**

Employee Name:	Position Title:
Department:	Division/Unit:
Date Completed:	No. of Hours per Work Day:
Completed By (Supervisor/Department Head):	Phone #:
<p><b>I. Physical Demands of Position</b>          Make the appropriate entry for each of the following items to describe the extent of the specific activity performed by this employee during the course of a typical work period.</p>	

Activity	None (0%)	Occasional (1-33%)	Frequent (34-66%)	Constant (66-100%)
1. Sitting				
2. Standing				
3. Walking				
4. Bending Over				
5. Climbing				
6. Reaching Overhead				
7. Kneeling				
8. Pushing or Pulling:				
a. With Legs				
b. With Arms				
c. With Body				
9. Lifting or Carrying:				
a. 10lbs or less				
b. 11 to 25lbs.				
c. 26 to 50lbs.				
d. 51 to 75lbs.				
e. 76 to 100lbs.				
f. Over 100lbs.				
10. Repetitive Use of Foot Control:				
a. Right Only				
b. Left Only				

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c. Both				
11. Repetitive Use of Hands:				
a. Right Only				
b. Left Only				
c. Both				
12. Simple/Light Grasping:				
a. Right Only				
b. Left Only				
c. Both				
13. Firm/Strong Grasping:				
a. Right Only				
b. Left Only				
c. Both				

14. Is employee required to drive a car? Yes or No (Circle one). If yes, please describe:

15. Is employee required to operate heavy equipment? Yes or No (Circle one). If yes, please describe:

16. Is employee exposed to dust, gas, or fumes? Yes or No (Circle one). If yes, please explain:

17. Is employee exposed to marked changes in temperature or humidity? Yes or No (Circle one). If yes, please explain:

18. Describe the employee's specific shifts (including rotating) and/or the hours worked, any travel requirements, and overtime:

**II. Physician's Release**

Please check the appropriate box below and provide comments as necessary.

I release the above named employee to return to work without restriction to the position as described above as of \_\_\_\_\_ (effective date).

I am unable to release to this position as describe above.

The medical rationale for this is:

Comments:

Physician's Signature:	Date:
Physician's Name (Please Print)	Phone #: