



MONTANA CONSERVATION CORPS

Physician's Medical Release

Attending Doctor/Physician,

To support our members, Montana Conservation Corps has developed an Early Return to Work program which includes Modified and Light Duty options. We want members to return to work within their functional capacities as soon as they are able. Members routinely perform a variety of strenuous manual labor and repetitive motion tasks, such as trail building, fencing, and re-vegetation projects. If members are unable to return to their full duties immediately, we will do everything possible to modify those duties. The information in this form is used to help us develop appropriate light duty work. Please read the below criteria and evaluate whether or not, in your medical opinion, the patient will be fit for work re-entry and if so, by what date.

- Lift up to 30 lbs repeatedly
 - Hiking and working on terrain that can be steep, rocky or uneven
 - Swing or operate 10 -20 lb tools using a repetitive motion (sledge hammers, Pulaski's, axes, chainsaws)
 - Hike distances of up to 12 miles while carrying a 45+ lbs backpack, sometimes at high altitude
 - Spend between 1-3 weeks in a backcountry setting without running water, sanitation facilities or access to immediate professional medical care
 - Work 8-10 hour days in any weather condition, sometimes at high altitude
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To be completed by physician or other medical provider:

Patient: _____

- Patient may return to work with no restrictions.
- Patient may return to work with no restrictions on _____ date.
- Patient will need a follow-up visit on _____ before being cleared to return to work.
- Patient may resume modified duties on _____ with restrictions. If the member is unable to return to regular duties, please assist us by indicating the member's physical limitations below.
- Patient will not be able to return to work under any circumstances.

For Workers Compensation Claimants Only:

Claim # _____

Patient is at maximum medical improvement as of _____ and has a _____ permanent whole person impairment.

Physician's Comments/Restrictions:

Physician's signature: _____ Date: _____

Please provide the member with a copy of this form to return to our office.