FranklinPierce UNIVERSITY

Return to Work Authorization Form

EMPLOYEE: _____

WAS SEEN ON: _____

FOR: _____ office visit _____ injury treatment _____ follow-up

Other: _____

NEXT APPT: _____
(If applicable)

RECOMMENDATION:

_____ May NOT Work

_____May return to work on: _____
(mm/dd/yyyy)

If employee may return to work, please specify:

_____ Return to work at Full-Duty (No Restrictions)

_____ Return to work at Modified Duty with the following restrictions:

_____ Hours per day

_____ Light duty: (Please explain what employee may/may not do below)

_____

_____

_____

Other: (please specify) _____

_____

_____ _____ _____
(Print) Name of Health Care Provider Signature Date

_____ _____
(Print) Name & Type of Practice Phone number (w/area code)