

# Return to Work Form From Doctor

Title: Return to Work Form From Doctor

## Section 1: Employee Information

- Full Name: \_\_\_\_\_
- Employee ID: \_\_\_\_\_
- Department: \_\_\_\_\_
- Contact Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_

## Section 2: Doctor's Information

- Doctor's Full Name: \_\_\_\_\_
- Medical Facility: \_\_\_\_\_
- Address: \_\_\_\_\_
- Contact Number: \_\_\_\_\_

## Section 3: Medical Details

- Date of Injury/Illness: \_\_\_\_\_
- Nature of Injury/Illness:  
\_\_\_\_\_  
\_\_\_\_\_

## Section 4: Work Clearance

- Date of Examination: \_\_\_\_\_
- Clearance Date to Return to Work: \_\_\_\_\_

## Section 5: Work Restrictions

- Any Restrictions? (Check one):

Yes

No

- If yes, specify restrictions:

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### Section 6: Follow-Up Appointments

Date	Time	Purpose	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_

### Section 7: Doctor's Certification

- I certify that the above information is true and accurate.

• Doctor's Signature: \_\_\_\_\_

• Date: \_\_\_\_\_