Return to Work Form PDF

Title: Return to Work Form

Section 1: Employee Details

- **Full Name: ____**
- **Employee Number: _____________________________________**
- **Department: ____**
- **Contact Number: ______________________________________**
- **Email Address: ____**

Section 2: Physician Information

- **Physician's Name: ______________________________________**
- **Medical Facility: _______________________________________**
- **Address: ____**
- **Phone Number: ____**

Section 3: Medical Evaluation

- **Date of Injury/Illness: ____________________________________**
- **Type of Injury/Illness:**

  ____

  ____

Section 4: Work Status

- **Date of Medical Assessment: ______________________________**
- **Cleared to Return to Work on: _____________________________**

Section 5: Restrictions and Limitations

- **Does the employee have any restrictions? (Check one):**

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- ☐ Yes
  - ☐ No
- **If yes, describe restrictions:**

  ____

  ____

Section 6: Follow-Up Appointments

Date	Time	Reason	Notes
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______
_____	_____	_______	______

Section 7: Physician's Statement

- **I hereby certify the above information is accurate.**
- **Physician's Signature: ____**
- **Date: ____**________________

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