Simple Return to Work Form

Title: Simple Return to Work Form

Section 1: Employee Information

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

Section 2: Physician Information

- **Physician's Name: _____________________________________**
- **Medical Facility: ______________________________________**
- **Address: ____**
- **Contact Number: ______________________________________**

Section 3: Medical Evaluation

- **Date of Injury/Illness: ____________________________________**
- **Nature of Condition:**

____

____

Section 4: Work Clearance

- **Date of Examination: ____________________________________**

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- **Return to Work Date: ____**

Section 5: Work Restrictions

- **Any Work Restrictions? (Check one):**
  - ☐ **Yes**
  - ☐ **No**
- **If yes, please describe:**

____

____

Section 6: Follow-Up Appointments

Date	Time	Reason	Additional Notes
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________
_____	_____	_______	___________________

Section 7: Certification

- **I certify that the information provided is accurate and complete.**
- **Doctor's Signature: ____**

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- **Date:** ____

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