

Doctor's Return to Work Form

Employee Information

- Employee Name: _____
- Employee ID: _____
- Job Title: _____
- Department: _____

Medical Provider Information

- Medical Provider Name: _____
- Medical Facility Name: _____
- Phone Number: _____
- Email Address (if applicable): _____

Medical Assessment

- Condition/Injury/Illness Treated: _____
- Date of Diagnosis: _____
- Date of Treatment: _____
- Has the Employee Recovered Fully?
 - Yes
 - No
- Are There Any Work Restrictions or Limitations?
 - Yes (Specify below)

 - No
- Does the Employee Require Follow-Up Appointments?
 - Yes (Date of Next Appointment: _____)
 - No

Return to Work Details

- **Date Employee Can Return to Work:** _____
- **Type of Return:**
 - Full-Time
 - Part-Time (Specify Schedule): _____
- **Medical Restrictions (if any):**
 - No Restrictions
 - Lifting Limitations (Specify weight limit): _____
 - Standing/Sitting Duration Limits (Specify hours):

 - Other (Please specify): _____

Medical Provider Certification

I certify that the above information is accurate and the employee is fit to return to work with/without restrictions as noted.

Medical Provider Signature: _____

Date: _____

Employee Acknowledgment

I have reviewed the above information with my medical provider. I acknowledge the medical restrictions and agree to comply with the return-to-work plan.

Employee Signature: _____

Date: _____

Employer/Supervisor Acknowledgment

- **Reviewed by:** _____
- **Title:** _____
- **Date:** _____

- **Comments:**
