

# 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:**

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