

Return to Work Checklist After Injury

Employee Information

- Employee Name: _____
- Employee ID: _____
- Job Title: _____
- Department: _____
- Supervisor/Manager Name: _____

Injury Details

- Date of Injury: _____
- Location of Injury (Onsite/Offsite): _____
- Nature of Injury: _____
- Medical Treatment Received?
 - Yes (Attach medical documentation)
 - No

Return to Work Readiness

- Doctor's Clearance Provided?
 - Yes (Attach clearance form)
 - No
 - Does the Employee Have Medical Restrictions?
 - No
 - Yes (Specify below)
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- **Can the Employee Perform Their Full Duties?**

- Yes
 - No (Specify required accommodations)
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Workplace Adjustments (if applicable)

- Adjusted Work Schedule (Specify): _____
- Temporary Duties Assigned (Specify): _____
- Ergonomic Adjustments Made (Specify): _____
- Other Adjustments (Specify): _____

Employee Acknowledgment

I have reviewed the return-to-work plan and agree to comply with the conditions outlined.

Employee Signature: _____

Date: _____

Supervisor/Manager Review

- **Reviewed by:** _____
 - **Title:** _____
 - **Date:** _____
 - **Comments:**
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HR Department Use

- **Reviewed by (HR Representative):** _____
 - **Date:** _____
 - **Additional Notes:**
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