

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)

- **Can the Employee Perform Their Full Duties?**

☐ Yes

☐ No (Specify required accommodations)

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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