Return to Work Form

Section 1: Employee Information

- **Name:**_____
- **Employee ID:** _____
- **Department:** _____
- **Phone Number:**_____
- **Email Address:** _____

Section 2: Doctor's Information

- **Doctor's Name:** _____
- **Medical Practice:** _____
- **Address:** _____
- **Email Address:** _____
- **Contact Number:** _____

Section 3: Medical Summary

- **Date of Injury/Illness:**

  _____
- **Diagnosis:**_____

  _____

  _____

Section 4: Return to Work Authorization

- **Date of Examination:** _____
- **Authorized Return Date:** _____

Section 5: Work Restrictions

- **Are there any restrictions? (Check one):**
  - ☐ **Yes**
  - ☐ **No**

- **If yes, specify:**

  _____

  _____

  _____

Section 6: Follow-Up Schedule

Date	Time	Follow-Up Reason	Comments
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____
____	____	_____	_____

Section 7: Doctor's Certification

- **I confirm that the above information is accurate.**
- **Doctor's Signature:**

  _____

- **Date:**

  _____