Return to Work Medical Release Form

Instructions: This form must be completed by a licensed medical provider before the employee is permitted to return to work. Please fill out all fields clearly.

Employee Information

Employee Full Name:

Date of Birth: MM/DD/YYYY

Job Title / Position:

Department:

Medical Provider Information

Physician / Medical Provider Name:

Clinic / Practice Name:

Office Phone Number:

Medical Release & Return to Work Status

Date of Medical Examination: MM/DD/YYYY

Effective Date of Return to Work: MM/DD/YYYY

Work Status (Full Duty / Modified Duty): Enter status

Work Restrictions (If Applicable)

Please detail any restrictions, limitations, or accommodations needed below.

Lifting / Carrying Restrictions (e.g., maximum weight):

Postural / Mobility Restrictions (e.g., standing, bending, sitting):

Other Restrictions or Special Accommodations:

Restrictions Expected Duration (or Expected Full Release Date): MM/DD/YYYY or Perma

Provider Authorization and Signature

I certify that the above-named employee has been under my medical care and is medically cleared to return to work under the conditions outlined above.

Medical Provider Signature (Sign upon printing): Sign here

Date of Signature: MM/DD/YYYY