Return to Work Medical Authorization Form

This form is used to document medical clearance for an employee returning to work after a medical leave. Please print, complete, and have this signed by a licensed healthcare provider.

Employee Information

Employee Full Name:	
Job Title:	
Department / Division:	
Last Day Worked:	MM/DD/YYYY

Healthcare Provider Details

Provider Name (Printed):	
Medical Specialty:	
Clinic or Practice Name:	
Phone Number:	

Medical Release Status

Please indicate the returning employee's work clearance status:

Cleared for Full Duty (No Restrictions) Effective Date:	MM/DD/YYYY
Cleared for Modified Duty Effective Date:	MM/DD/YYYY

Work Restrictions (If Applicable)

Please detail any physical or medical limits (e.g., lifting weight, standing duration, hourly restrictions):

Lifting / Carrying Limit (in lbs):	
Standing / Walking Limit (hours per day):	
Other Specific Restrictions:	
Expected Duration of Restrictions:	e.g., 2 weeks, permanent

Signatures

By signing below, the medical professional certifies that the employee is medically cleared to resume duties as indicated above.

Healthcare Provider Signature:	Sign here upon printing	Date:	MM/DD/YYYY
Employer Representative Signature:	Sign here upon receipt	Date:	MM/DD/YYYY