

Return-to-Work Medical Clearance Form

Employee Information

Name:

Employee ID:

Department:

Date of Birth:

Medical Information

Diagnosis:

Treatment Provided:

Are there any work restrictions?

☐ Yes ☐ No

If yes, please specify:

Physician Clearance

Date employee is cleared to return to work:

Physician's Name:

Physician's Signature:

Date:

Submit