Return to Work

_____ was treated at our facility.

Attending Caregiver: _____

☐ Employee has been advised to make a follow-up appointment in _____ days.
☐ Follow-up appointment has been made for: _____ at _____

INJURY OR ILLNESS WAS:
☐ Work-related
☐ Not work-related
☐ Undetermined if work-related

RETURN TO WORK
- Employee may return to work on: _____
- Employee may return to modified work on: _____

WORK ACTIVITY RESTRICTIONS
Work activities not tolerated include:

☐ Bending	☐ Prolonged sitting	☐ Lifting
☐ Squatting	☐ Prolonged standing	☐ Climbing
☐ Reaching	☐ Pushing & pulling	☐ Walking
☐ Other _____		

Show this **Return to Work** statement to your supervisor at work as soon as possible. Your employer should be aware of your condition and can help with the necessary work activity restrictions. If you wish to return to work sooner than the date above, or if you have further problems which make it difficult for you to return at that time, please call us or your personal caregiver.

_____ _____
Physician Name (Printed) Physician Signature

_____
(Date)

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