EARLY & SAFE RETURN TO WORK PROGRAM – RETURN TO WORK FORM

DATE: _____

EMPLOYEE NAME: _____

ADDRESS: _____

_____

CONTACT NUMBER: _____

To Whom It May Concern:

This is to certify that the above named patient is able to return to:

☐Regular work duties on _____

☐Modified work duties from _____ to _____
(DATE) *(DATE)*

with the following limitations during this period:

LIMITATIONS:_____

_____

_____

_____

_____

_____

_____

_____

_____

PHYSICIAN'S NAME & SIGNATURE

_____

DATE