RETURN TO WORK CERTIFICATION

Name _____
(Please Print)

Department/Job Title: _____

This form must be completed by the employee's physician.

I have examined the employee noted above and hereby certify that:

MAY RETURN TO WORK WITHOUT RESTRICTIONS _____
DATE

MAY RETURN TO WORK WITH RESTRICTIONS

Restrictions are as follows: Employee cannot:

_____ use _____hand (left/right)

---------- walk

----------climb stairs

---------- operate vehicle

---------- lift; may lift up to _____ pounds

_____ bend

_____ sit and/or stand all day

How long will these restrictions be in effect: _____

MAY NOT RETURN TO WORK

Diagnosis: _____

Date of re-evaluation: _____

Return to work on _____

Name of Physician: _____

Address & Telephone # _____

_____ _____
(Signature of Treating Physician **(Date)**