TOWN OF WALPOLE

RETURN TO WORK DATE: _____

Employee's Name: _____

Department/Job Title: _____

***PLEASE COMPLETE THE APPROPRIATE SECTION**

***MAY RETURN TO WORK**

_____ The Employee may return to work without restrictions.

***MAY NOT RETURN TO WORK DUE TO THE FOLLOWING RESTRICTIONS:**

_____

_____

_____

_____

*How long should these restrictions be in effect: _____

***MAY RETURN TO WORK ON:**

_____ Return to work on _____
date

* Diagnosis: _____

* Date of re-evaluation: _____

Town of Walpole
Personnel
135 School Street
Walpole, MA 02081
508-660-7294

Signature _____ M.D.
Address _____
_____
_____
Telephone _____