

**CERTIFICATE FOR RETURN TO WORK  
OR FURTHER TREATMENT**

Name of Employee \_\_\_\_\_ Job Title \_\_\_\_\_ Date \_\_\_\_\_

Industrial Injury    Yes    No

Diagnosis \_\_\_\_\_

The above employee has been under my care from \_\_\_\_\_ (Date).

He/she may return to full work duties on \_\_\_\_\_ (Date) and does not have to return for any further treatment. (Completely released)

He/she may return to full work duties on \_\_\_\_\_ (Date) but has another appointment with this office on \_\_\_\_\_ (Date) at \_\_\_\_\_ (Time).

He/she may return to work modified to accommodate the following restrictions on \_\_\_\_\_ (Date). but has another office appointment on \_\_\_\_\_ (Date) at \_\_\_\_\_ (Time).

**Patient is restricted from:**

- |                    |                       |                 |          |
|--------------------|-----------------------|-----------------|----------|
| Bending            | Use of Ladder         | Kneeling        | Running  |
| Reaching           | Prolonged Sitting     | Work at Heights | Climbing |
| Prolonged Standing | Lifting _____ (Limit) |                 |          |

Doctor's Statement \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

**PLEASE TYPE:**

License No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

He/she not return to work before this office has seen him/her on \_\_\_\_\_ (Date) at \_\_\_\_\_ (Time).

Status - Restrictions: Yes \_\_\_ No \_\_\_  
Approved: Yes \_\_\_ No \_\_\_

Return original and all copies to your Supervisor. Supervisor to forward copies to Personnel/Human Resources, Insurance and Payroll.

Supervisor: \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Personnel: \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_