Return to Work Doctor's Note

_____

[Healthcare Provider's Name]

_____

[Healthcare Provider's Address]

_____

[Healthcare Provider's Phone Number]

Date:

To:

_____

[Employer's Name]

_____

[Employer's Address]

Patient Name:

_____

[Patient's Name]

_____

[Patient's Date of Birth]

Diagnosis:

Date of Last Examination:

Current Restrictions or Limitations:

Recommended Accommodations or Modifications:

Date of Clearance to Return to Work:

Healthcare Provider Signature: