Doctor’s Return to Work Note Template

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| --- | --- |
| [Doctor’s Full Name]  [Doctor’s Speciality]  [Doctor’s Address]  [City, State, ZIP Code]  [Phone Number]  [Email Address]  [Date] | |
| **Patient Information:** | |
| Field | Information |
| Full Name: | [First Name][Last Name] |
| Date of Birth: | [MM/DD/YYYY] |
| Address: | [Complete Address] |
| City, State, Zip Code: | [City, State, ZIP Code] |
| Phone Number: | [0000-000-000] |
| Email Address: | [email@highfile.com] |
| **Employer Information:** | |
| Field | Information |
| Company Name: | [Company Name] |
| Address: | [Complete Address] |
| City, State, Zip Code: | [City, State, ZIP Code] |
| Supervisor Name: | [First Name][Last Name] |
| Supervisor Email: | [email@highfile.com] |
| **Medical Information:** | |
| Diagnosis: | [Diagnosis of the Patient] |
| Date of Initial Visit: | [MM/DD/YYYY] |
| Date of Last Visit: | [MM/DD/YYYY] |
| Treatment Provided: | [Provide Details about the Treatment] |
| Medications Prescribed: | [List of Medications if Applicable] |
| **Return to Work Information:** | |
| Date to Return to Work: | [MM/DD/YYYY] |
| Work Restrictions: | [Any Work Restrictions. If None, State None] |
| Follow-up Appointment Date: | [MM/DD/YYYY] |
| **Certification:** | |
| I certify that I have examined the patient, [Patient's Full Name], and attest to the information provided in this letter. | |
| Physician Full Name: | [First Name] [Last Name] |
| Physician Signature: | [Signature] |
| Date: | [MM/DD/YYYY] |