**RETURN TO WORK DOCTOR’S NOTE**

[Doctor’s Letterhead]

|  |  |
| --- | --- |
| Doctor’s Office Address: | [Complete Address] |
| City, State, ZIP Code: | [City, State, ZIP Code] |
| Phone Number: | [0000-000-000] |
| Email Address: | [email@highfile.com] |
|  | |
| **RETURN TO WORK MEDICAL CERTIFICATION FORM** | |
|  | |
| Date: | [MM/DD/YYYY] |
|  | |
| **PATIENT’S INFORMATION** | |
|  | |
| Patient’s Name: | [Full Name] |
| Address: | [Complete Address] |
| Date of Birth: | [MM/DD/YYYY] |
| Phone Number: | [0000-000-000] |
|  | |
| **MEDICAL INFORMATION** | |
|  | |
| Diagnosis: | [Details] |
| Treatment Provided: | [Details] |
| Date of initial Consultation: | [MM/DD/YYYY] |
| Period of Leave: | [Details] |
|  | |
| **FITNESS FOR WORK ASSESSMENT (Current Status)** | |
|  | |
| Fit to return to work with no restrictions | |
| Fit to return to work with the following restrictions/accommodations: [Description] | |
|  | |
| **LIFTING RESTRICTIONS** | |
|  | |
| No lifting restrictions | |
| Lifting restrictions apply as follow:  Maximum weight patient can lift: [15 lbs]  Further Details: [Details] | |
|  | |
| **FOLLOW-UP TREATMENT REQUIRED** | |
|  | |
| Yes | |
| No | |
| If yes, please provide details: [Details] | |
|  | |
| **DOCTOR’S INFORMATION** | |
|  | |
| Doctor’s Name: | [Full Name] |
| Doctor’s Signature: | [Signature] |
| Date of Signature: | [MM/DD/YYYY] |
| Medical License Number: | [Number] |
|  | |
| This form confirms that the patient named above is medically cleared to return to work as specified. If further information is required, please do not hesitate to contact my office. This medical information is confidential and only for use by the intended recipient.  This form was created by [Doctor’s Full Name] who is solely responsible for its information. | |