**Doctor’s Return to Work Note**

**Date:** DD/MM/YYYY

**Dr. [Name]**

**[Complete Address]**

**[Email - Web]**

**[Phone Number]**

Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury/surgery/illness: \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis or description of injury/surgery/illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The patients return to work status is:**

[\_\_\_] Return to regular work. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

[\_\_\_] Able to return to work with noted restrictions. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

[\_\_\_] Unable to return to work until next evaluation. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

[\_\_\_] Referred to another health care provider. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Lifting Restrictions:**

[\_\_\_] None

[\_\_\_] 20 – 30 lbs.

[\_\_\_] 30 – 40 lbs.

[\_\_\_] 40 - 50 lbs.

[\_\_\_] 50 - 60 lbs.

**Follow Up Plan of Treatment:**

[\_\_\_] None

[\_\_\_] Return visit on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at\_\_\_\_\_\_\_\_\_\_a.m./p.m.

**Additional Comments:**



Please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if you have any questions or need additional information.

**X**

# Dr. Full Name. MD

A blue square with white lines

Description automatically generated

#3376C3

#B02418

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(A B C D E F G H I J K L M N O P Q R S T U V W X Y Z)

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Description automatically generated

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