COMPANY NAME

Employee Consent & Return to Work Form

Company name is committed to ensuring a safe and early return to work for all of our employees. Our company can accommodate most temporary functional restrictions. Your assistance in returning our employee to work is appreciated.

Employee name: _____

Date of work injury / non-occupational injury or illness _____

(circle one)

PHYSICIAN'S OBJECTIVE FINDINGS **Date of exam:** _____

_____

_____

_____

_____

_____

1. (a) Is this person fit for **Regular** duty today? □ Yes □ No

   (b) Is this person fit for **Modified** duty today? □ Yes □ No

   (c) List any medical restrictions that should be observed in modified duties:

_____ _____

_____ _____

_____ _____

Employee can work for: □ 2 hrs/day □ 4 hrs/day □ 6 hrs/day □ 8 hrs/day

Estimated date of return to **Regular** duties: _____

2. **Is this person on medication(s) that would affect work performance or use of machinery?** □ Yes □ No
3. Will this employee be reassessed? □ Yes □ No If yes, when? _____
4. Additional comments:

_____

_____

_____

I, _____, authorize the release of the above information to Company .

Employee Signature: _____ Date: _____

_____ _____

Physician Name (please print) Signature

_____ _____

Telephone Number Date