Return to work release

The employee completes the first part. The health care provider completes the second.

Questions marked * need an answer.

Who sees this: [HR] only. It is kept apart from your personnel file. Providers: please do not include a diagnosis. Privacy policy: _____.

Employee

Completed by the employee.

1. Your name *

2. Job title *

3. Department

4. First day of leave *

Date

5. Type of leave *

- ◯ Own illness or injury
- ◯ Injury at work
- ◯ Other

6. Workers' compensation claim number

Only if "Type of leave" is Injury at work.

7. Job description

Optional. Helps your provider judge the essential duties. HR can attach it instead.
Attach this separately and write what you attached below.

8. How will your provider give the release? *

- ◯ My provider fills in the next section
- ◯ I will upload my provider's own signed release

9. Your provider's signed release *

Only if "How will your provider give the release?" is I will upload my provider's own signed release.
It must show the return date, any restrictions and the provider's signature.
Attach this separately and write what you attached below.

Health care provider’s release

Please limit your answers to the employee’s ability to do their job. Do not include a diagnosis or any genetic information.

10. Work status *

◯ Released to full duty ◯ Released with restrictions ◯ Not yet released

11. Date the employee can return, or is expected to *

Date

12. Can the employee perform the essential functions of their job? *

Only if “Work status” is not Not yet released.

◯ Yes ◯ No

13. Restrictions *

Only if “Work status” is Released with restrictions.

Hours, lifting limits and tasks to avoid.

14. The restrictions are *

Only if “Work status” is Released with restrictions.

◯ Temporary ◯ Permanent

15. Restrictions apply until *

Only if “Work status” is Released with restrictions and “The restrictions are” is Temporary.

Date

16. Next appointment or review date

Date

17. Could any medication affect safety at work, such as driving or using machinery?

◯ Yes ◯ No

18. Provider’s name and practice *

19. Provider’s phone number *

20. Provider’s signature *

Signature

Date

Employee sign-off

21. Employee’s signature

Confirms you have seen what your provider wrote.

Signature

Date