Medical Clearance Certificate for Employee Return

Employee Details

Name: _____

Employee ID: _____

Department: _____

Position/Title: _____

Date of Birth: _____

Medical Assessment

Diagnosis: _____

Date of Illness/Injury: _____

Date of Medical Evaluation: _____

Current Health Status:

Clearance

Is the employee fit to return to work? _____

Date of Return: _____

Remarks / Restrictions (if any):

Medical Professional Details

Name: _____

Designation: _____

License Number: _____

Date: _____

Signature: _____