

Physician Statement for Employee Fitness to Work

Employee Name

Employee ID (if applicable)

Date of Assessment

Diagnosis / Reason for Absence

Physician's Evaluation

Fitness to Work Status

Recommendations / Restrictions (if any):

Physician's Signature

Date

Physician's Name (print)

Clinic/Facility Name

Contact Information

This form is to be used by licensed medical professionals to certify the employee's ability to return to work, including any work-related restrictions or accommodations needed.

