Return-to-Work Medical Clearance Form

Employee Information

Name

Employee ID

Department

Position

Dates of Absence

e.g. 2024-05-01 to 2024-05-14

Medical Provider Section

General Reason for Absence

Medical Clearance Status

e.g. Cleared to return to work without restrictions

If restrictions/limitations apply, please describe

Date Cleared to Return to Work

Provider Information

Provider Name

Phone

Clinic/Facility Name & Address

Provider Signature
Date