## **Temporary Work Restriction Return Form**

Employee Name
Employee ID
Department
Supervisor
Date of Injury/Illness
Date of Return
Summary of Medical Restrictions
Temporary Work Assignments/Limitations
Duration of Restriction
Duration of Nestriction
Physician/Healthcare Provider Name
Dhyminian/Haalthaara Dravidar Cignatura
Physician/Healthcare Provider Signature
Date
Date
Superiser/Manager Comments
Supervisor/Manager Comments