

Workersâ€™™ Compensation Return to Duty Form

Employee Name

Employee ID

Department

Job Title

Date of Injury

Date of Return to Duty

Physician Name

Physician Phone

Work Status

Full Duty	Restricted Duty	No Duty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Restrictions/Limitations (if any)

Additional Comments

Physician Signature

Date

Employee Signature

Date