Return to Work Doctor's Note

Healthcare provider details:

Date:: _____ dd / mm / yyyy

To:

Patient name:: _____ Date of birth:: _____ dd / mm / yyyy

Diagnosis:: _____ Date of last examination:: _____ dd / mm / yyyy

Current restrictions or limitations:

Recommended accommodations or modifications:

Date clearance to return to work:: _____ dd / mm / yyyy

Healthcare provider's signature: