**Return-to-Work Medical Clearance Form**

**Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name:** | John Doe | **Employee ID:** | EMP-4587 |
| **Position/Title:** | Sales Associate | **Department:** | Sales |
| **Supervisor** |  | **Contact Number** |  |

**Section 1: Medical Leave Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Illness/Injury |  | Nature of Condition |  |
| Date Leave Began |  | Date of Expected Return |  |
| Was hospitalization required? | ☐ Yes ☐ No | If yes, duration of stay |  |

**Section 2: Medical Practitioner’s Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Physician |  | Clinic/Hospital Name |  |
| Contact Number |  | Date of Examination |  |
| Type of Assessment | ☐ Physical ☐ Mental ☐ Both | | |

**Medical Findings:**

|  |
| --- |
|  |
|  |

**Is the employee fit to resume full duties?**  
☐ Yes  ☐ No  ☐ With Restrictions

If **restrictions apply**, please specify:  
☐ Light duties only ☐ Reduced hours ☐ No heavy lifting ☐ Avoid standing long hours  
Other restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expected Duration of Restrictions (if any):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3: Certification by Medical Practitioner**

I certify that the above-named employee has been medically examined and is:  
☐ Fit to return to work ☐ Fit with conditions ☐ Not fit to return to work

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name:** | John Doe | **Signature:** |  |
| **Date:** |  | **Official Stamp:** |  |

**Section 4: Employer Acknowledgment**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Received |  | HR/Manager Name |  |
| Position |  | Signature |  |
| Comments |  | | |

**✅ Notes**

* This form must be completed and submitted **before returning to work**.
* All medical information will be treated as **confidential**.
* Additional documentation may be required if restrictions are noted.