**Return-to-Work Clearance Form**

*Required when employees return from medical or injury leave to confirm fitness to resume duties.*

1. **Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name | John Peterson | Employee ID | EMP-2741 |
| Department | Operations | Position/Job Title | Machine Operator |
| Supervisor | Michael Ross | Contact Number | (555) 334-8821 |
| Type of Leave | Medical / Injury / Surgery / Other | Reason for Leave | Lower back strain |
| Leave Start Date | 02-Feb-2025 | Expected Return Date | 12-Feb-2025 |

1. **Medical Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Physician/Provider Name | Dr. Laura Kim | Facility/Hospital/Clinic | City Medical Center |
| Contact Number | (555) 881-7721 |  |  |

**C. Medical Clearance (To Be Completed by Healthcare Provider)**

**1. Medical Condition Status:**

* ☐ Fully Recovered
* ☐ Partially Recovered
* ☐ Requires Ongoing Treatment
* ☐ Not Fit for Work

**2. Employee is cleared to return to work on:**  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Work Ability Status:**

* ☐ Fit for full duties without restrictions
* ☐ Fit for duties with temporary restrictions
* ☐ Not fit for duties; needs extended leave until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Restrictions (if any):**

* ☐ No heavy lifting above \_\_\_\_\_ lbs
* ☐ Limited standing/walking (max \_\_\_\_\_ hours/day)
* ☐ Limited bending/twisting
* ☐ Reduced work hours (\_\_\_\_\_ hours/day)
* ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Medication Considerations (if applicable):**  
Does medication affect employee’s alertness or safety?

* ☐ Yes
* ☐ No

|  |  |  |  |
| --- | --- | --- | --- |
| If yes, describe: |  | | |
| **Healthcare Provider Signature:** |  | **Date:** |  |
| **Stamp (if available):** |  | | |

**D. Employer Review & Clearance**

**1. HR / Supervisor Notes:**

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| --- |
|  |
|  |
|  |

**2. Fit to Resume Duties:**

* ☐ Approved
* ☐ Approved with accommodations
* ☐ Not Approved – further evaluation needed

|  |  |  |  |
| --- | --- | --- | --- |
| **Reviewed By:** |  | **Title:** |  |
| **Date:** |  |  |  |

**E. Employee Acknowledgment**

I acknowledge that I have been medically cleared to return to work and understand any restrictions provided.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**F. Additional Comments (Optional)**

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