RETURN TO WORK ORDER

INSTRUCTIONS TO ATTENDING DOCTOR: IMMEDIATELY UPON PATIENT BEING ABLE TO RESUME WORK, PLEASE COMPLETE THIS FORM IN DUPLICATE. SEND ORIGINAL TO INSURANCE CARRIER AND GIVE PATIENT A SIGNED COPY.

Name of injured Employee ______________________ Date of injury ____________

Name of Employer ______________________________________

This is to certify the above named employee

☐ will be ☐ was able to return to work on ______________________

Remarks ______________________________________

____

Doctor's Name ______________________________________

Personal Signature of Doctor ______________________________________

Doctor's Address ______________________________________

Dated ______________________________________

INSTRUCTIONS TO PATIENT: Present your copy to Employer upon returning to work.

#10

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SAMPLE