



## Return to Work Certification

Employee Name \_\_\_\_\_

Date the employee may return to work \_\_\_\_/\_\_\_\_/\_\_\_\_

List below any restrictions or accommodations that are necessary and related to the employee's work

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Employee Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

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Signature of Health Care Provider

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date