Frederick Health

Return to Duty Authorization Form

Name

First Name

Last Name

Birth Date:

Date Released to Work:

○ Full Duty ○ With Restrictions

Department:

If returning after childbirth, date employee plans to return to work:

Month Day Year

Duration of Restrictions:

Restrictions:

- ☐ No Lifting > _____ lbs
- ☐ No Pushing/Pulling > _____ lbs
- ☐ No Patient Lifting or Transfers
- ☐ Limited Work Hours as Follows: _____
- ☐ Sit/Stand as Follows: _____
- ☐ Other:

Follow-Up Appointment Date:

Month Day Year

_____

Treating Physician (Printed Name)

_____ _____

Treating Physician (Signature) Date

_____ _____

Employee Health (Signature) Date