Washington University in St. Louis
SCHOOL OF MEDICINE

Return to Work Form

To be completed by healthcare provider prior to returning to work.

Fitness for Duty:

I have examined ______________________________ and can certify that he/she is:
Employee Name

___ fully able to resume working as of ________________________.
Date

___ able to return to work on ________________ with the following restrictions:
Date

____

____

____

____
Healthcare Provider's Signature

____
Type of Practice

____
Printed Name of Healthcare Provider

____
Telephone Number

____
Address

____
Date