

**HARVARD - RETURN TO WORK FORM**

Employee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Medical clearance to return to work on date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Please indicate specific date)** |

|  |  |  |
| --- | --- | --- |
|  \_\_\_\_\_\_ Regular Duty/ No Restrictions  |  \_\_\_\_\_\_ No Driving (explain below)  |   |
|  \_\_\_\_\_\_ Modified Duty (explain below)  |  \_\_\_\_\_\_ No Equipment Operation (explain below)  |   |
|  \_\_\_\_\_\_ Reduced Hours (explain below)  |  \_\_\_\_\_\_ Work Restrictions (explain below)  |   |
|  \_\_\_\_\_\_ Duration of impairment (explain below) |  |
|  \_\_\_\_\_\_ Hours/Days (if restricted, what Days/Hours Per day)  |   |
| **OTHER and/or Explanation from item(s) marked above:**  |

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**Physician Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax this form to your local Human Resource office.**