

**HARVARD - RETURN TO WORK FORM**

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

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

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| --- | --- | --- | --- |
| \_\_\_\_\_\_ 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.**