

Return to Work Form

(to be completed by supervisor)

Name of Employee _____

Current Position _____

Workman’s Comp Light Duty/Duties Assigned:

Beginning Date of Light Duty _____

My signature below indicates that I understand that this is a temporary assignment based on the physician’s recommendation.

Signature of Employee _____

Date _____

Signature of Supervisor _____

Date _____

Please attach copy of Doctor’s return to work form or letter and forward to Human Resources.