

Employee Health Services

Jackson Medical Towers, 11th Floor, Suite 1129
305-585-6903

JHS-ReturnToWork@jhs-miami.org

Healthcare Provider Evaluation Form Return to Work Clearance

HEALTH CARE PROVIDER MUST PROVIDE RETURN TO WORK CERTIFICATION BY COMPLETING THIS FORM

Employee's Name: _____ Phone Number: _____ DOB: _____

Date medically clear to return to work: ____/____/____

Diagnosis or description of injury/surgery/illness: _____

Patient's return to work status:

Return to full duty Date: ____/____/____
 Return to work with noted restrictions From Date: ____/____/____ To Date: ____/____/____

Detailed Restrictions: _____

***If Restrictions, employee must be seen at the clinic**

Health Care Provider's Signature _____
Print Name _____
Phone Number: _____ Date _____
Address City and State Zip: _____

MD Office Stamp

EMPLOYEE HEALTH SERVICES USE ONLY

EHS Review Type: **Clinic Visit** **Email:**

Time Arrived: _____ Time with Provider: _____ Time Discharged: _____

Status Dates: Return to full duty on: _____ R.A.C Referral: _____

Discharge Instructions/Restrictions: _____

Cleared to Return to Work: YES NO Need to Follow-Up with EHS

Nurse Examiner Name/Signature: _____ Date: _____

Employee must complete:

I UNDERSTAND THE ABOVE INSTRUCTIONS AND MY RESPONSIBILITY FOR FULL COMPLIANCE:

EMPLOYEE SIGNATURE: _____ Date: _____

Supervisor Name: _____

Supervisor Phone: _____ Email: _____