Return to Work Form

Complete Part A for every return. Complete Part B only when the absence was for the employee's own serious health condition, a work injury or another reason where the company's written policy requires medical clearance. Medical documents go to HR and are stored separately from the personnel file. Do not ask the employee for a diagnosis.

PART A. EMPLOYEE AND ABSENCE DETAILS

Employee name

Employee ID

Job title

Department / site

Manager

First day of absence

Return date

Total scheduled shifts or days missed

Type of absence

☐ Sick leave (own illness) ☐ Caring for a family member ☐ FMLA / protected leave
☐ Work-related injury or illness ☐ Personal / unpaid leave ☐ Bereavement ☐ Other

Was the absence reported according to the call-out procedure?

☐ Yes ☐ No ☐ Not applicable (approved in advance)

PART A. RETURN TO WORK CONVERSATION

Date of conversation

Employee confirms they are ready to resume their normal duties

☐ Yes ☐ Yes, with restrictions (see Part B) ☐ Not sure, referred to HR

Anything the company can do to support the return (schedule, workstation, equipment, follow-up check-in)

Work updates shared with the employee (process changes, schedule, open tasks)

☐ Employee informed of employee assistance program and how to request an accommodation

Follow-up check-in date, if any

PART B. MEDICAL CLEARANCE (ONLY WHERE REQUIRED BY WRITTEN POLICY)

Clearance type

☐ FMLA fitness for duty certification ☐ Work injury release (workers' compensation)

☐ Other medical release under company policy

Health care provider name and phone

Provider confirms the employee can return to work on

Provider confirms the employee can perform the essential job functions listed in the attached job description

☐ Yes, without restrictions ☐ Yes, with restrictions listed below ☐ No

Work restrictions (for example lifting limit, hours per day, no ladder work) and expected duration

Date restrictions will be reviewed

Provider signature

Date

Date

PART C. HR REVIEW

Restrictions can be accommodated in the current role

☐ Yes ☐ Yes, with changes listed below ☐ No, interactive process started ☐ Not applicable

Accommodations or modified duties agreed

- [ ] Leave records updated (FMLA hours, sick leave balance, workers' compensation file)
- [ ] Medical documents stored in confidential medical file

SIGNATURES

Employee signature

Date

Date

Manager signature

Date

Date

HR representative signature

Date

Date