## RETURN-TO-WORK PROGRAM PROVIDER FORM

To: Health Care Provider	Subject: Employee:
From: Company Name	SS#:
	at to return to work as soon as possible and assist this institution. The information you provide on ng considerations:
the needs of this institution.	nout risk of further injury; if necessary that meets the employee's needs and ble accommodations to aid the employee in
The employee's job description is attached for yo	our consideration:
Regular Job Description Te	emporary Assignment Job Description
If you have any questions regarding the informat	ion requested on this form, please contact:
Name & Title of Hosting Department Supervi	sor Telephone Number
TO BE COMPLETED BY F  Considering this employee's job duties and healt the following manner:	HEALTH CARE PROVIDER th condition, this employee may perform work in
Full Duty (no restrictions) Regular Job Description	Beginning:
Less than Full Duty (some restrictions) Temporary Assignment Job Descrit Additional Restrictions to Temporary Assignment Job Description.	ssignment Job Description should be noted on the
Off Work until Re-evaluated by Provider Next Office Visit Scheduled:	6 6
Health Care Provider's Signature	Date