Return to Work Certificate

Name		**Age**		**Phone**	
Company name & Address				**Date of Injury or illness**	

☐	**Patient may return to work with no limitations or restrictions from:**
☐	**Patient may return to work on with the below mentioned restrictions & limitations.**

Limits & Restrictions	
Duration of activity per day	
Lifting limitations & restrictions	
Duration of standing activity	
Walking duration & restrictions	
Seated activity & restrictions	
Driving limits	
Activities to be specifically avoided	
Others	
Comments & Notes	

Doctor's name & signature		**Address & Contact details**	