

STATE DISABILITY INSURANCE (SDI)

Doctor Certification for Return to Duty

This form must be completed by the attending physician or authorized medical practitioner to certify the patient's capacity to return to work. Please fill out all relevant sections completely.

1. PATIENT & CLAIM INFORMATION

Patient Full Name

Date of Birth

SDI Claim Number

Social Security Number / ID

2. CLINICAL ASSESSMENT & RETURN TO WORK DATE

Date of Last Examination

Effective Date of Release to Work

3. WORK CAPABILITY & RELEASE STATUS

Select the appropriate work status option below based on the clinical evaluation.

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Released to Full Duty (No Restrictions): The patient may return to regular work duties on a full-time basis without limitations.

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Released to Modified / Restricted Duty: The patient may return to work with the specific restrictions outlined below.

Expected Duration of Modified Duty

From Date

To Date (Estimated)

Work Limitations / Specific Restrictions

Activity	Restriction Details / Maximum Capacity
Lifting / Carrying	
Standing / Walking	
Sitting	
Bending / Stooping / Twisting	
Other Restrictions	

4. MEDICAL PRACTITIONER CERTIFICATION & SIGNATURE

I hereby certify that I have medically examined the patient named above and that the return to work information provided is true, accurate, and based on my clinical findings.

Practitioner Name

License Number

Facility Name & Address

Phone Number

Signature of Attending Medical Practitioner

Date