

STATE DISABILITY INSURANCE

Return to Work Clearance Form

1. EMPLOYEE / CLAIMANT INFORMATION

Full Name:

Date of Birth:

Claim Number:

Phone Number:

Employer Name:

Job Title:

2. MEDICAL RELEASE STATUS

To be completed by the attending healthcare provider. Select the appropriate status below:

☐

Full Release (No Restrictions): The patient is medically cleared to return to their full, regular work duties without any physical or mental limitations.

Effective Date:

☐

Modified Release (With Restrictions): The patient is medically cleared to return to work with the specific restrictions outlined in Section 3 below.

Start Date:

Estimated End Date:

3. SPECIFIC WORK RESTRICTIONS (IF APPLICABLE)

☐

No lifting over _____ lbs.

☐

No repetitive bending / twisting.

☐

No repetitive pushing / pulling.

☐

No climbing ladders / stairs / scaffolding.

☐

No operating heavy machinery.

☐

Limit standing / walking to _____ hours per day.

☐

Limit sitting to _____ hours per day.

☐

Limit keyboard / computer use to _____ hours per day.

☐

Sedentary work only.

☐

Other restrictions (specify below).

Other Restrictions details:

4. ATTENDING HEALTHCARE PROVIDER INFORMATION & SIGNATURE

Provider Name:

Medical License Number:

Facility Name:

Phone Number:

Facility Address:

Provider Signature:

Date: