

EMPLOYEE RETURN TO WORK NOTICE

State Disability Insurance (SDI) Claim Documentation

EMPLOYEE & EMPLOYER INFORMATION

Employee Name: _____

Claim / SSN (Last 4): _____

Employer Name: _____

Supervisor / HR Contact: _____

DISABILITY & RETURN TO WORK DETAILS

Disability Start Date: _____

Expected Return Date: _____

Actual Return Date: _____

Return to Work Status:

☐ Full Duty (No Restrictions) ☐ Modified / Transitional Duty ☐ Part-Time Duty

WORK RESTRICTIONS (IF APPLICABLE)

If returning with restrictions, please specify the temporary accommodations, physical limitations, or modified schedule details below.

Restrictions Effective Until (Date): _____

AUTHORIZED MEDICAL PRACTITIONER RELEASE

I hereby certify that the above-named employee has been under my care and is medically cleared to return to work on the date and under the conditions specified above.

Physician/Practitioner Signature _____ Date _____

Practitioner Name & License Number _____ Phone Number _____

EMPLOYEE & EMPLOYER ACKNOWLEDGEMENT

By signing below, both parties acknowledge receipt of this return-to-work clearance and agree to any specified transitional accommodations.

Employee Signature

Date

Employer Representative Signature

Date

Instructions: Please complete this form in full. The employee must submit the completed form to the Human Resources department prior to or on their first day back to work. A copy of this notice may also need to be submitted directly to the State Disability Insurance department to update the claim status.