

STATE DISABILITY INSURANCE PROGRAM

Return to Work Medical Certification

This form must be completed by a licensed healthcare practitioner to certify the claimant's medical clearance to return to work.

1. CLAIMANT / PATIENT INFORMATION

FULL NAME

CLAIM NUMBER

DATE OF BIRTH

MAILING ADDRESS

2. MEDICAL RELEASE STATUS

☐

Full Release (No Restrictions): The patient is medically cleared to return to full, unrestricted duty in their regular occupation.

EFFECTIVE DATE OF FULL RELEASE

☐

Modified Release (With Restrictions): The patient is medically cleared to return to work with the temporary modifications listed below.

EFFECTIVE FROM DATE

ESTIMATED END DATE OF RESTRICTIONS

SPECIFIC WORK RESTRICTIONS AND LIMITATIONS

3. HEALTHCARE PRACTITIONER INFORMATION & CERTIFICATION

PRACTITIONER NAME & TITLE

LICENSE NUMBER

FACILITY ADDRESS

TELEPHONE NUMBER

PRACTITIONER SIGNATURE

DATE SIGNED

4. CLAIMANT ACKNOWLEDGMENT

I acknowledge that I have received a copy of this return-to-work certification and agree to comply with any medical restrictions outlined above.

CLAIMANT SIGNATURE

DATE SIGNED