SUPERVISOR'S REPORT OF RETURN TO WORK FORM

INSTRUCTIONS: The supervisor shall fill out this form and then submit it to the Worker's Compensation Coordinator. Attach the Employee Return to Work Plan and submit it in addition to this form.

TO: WORKERS' COMPENSATION COORDINATOR

FROM: SUPERVISOR NAME	DEPARTMENT / AREA

	EMPLOYEE NAME	DATE OF RETURN
The following employee has returned to work:		

THE EMPLOYEE IS: check all that apply

	Performing their full duties with no restrictions.			
	Performing their duties with restrictions.			
	Has returned in a Transitional Work effort; and / or alternative duty has been assigned with restrictions.			
	Working their full schedule.			
	Working a partial day:	NO. OF HOURS PER DAY	START TIME	END TIME

COMMENTS:

	NAME	SIGNATURE	DATE
INJURED WORKER			
SUPERVISOR			

*** RETURN COMPLETED FORM TO WORKERS' COMPENSATION COORDINATOR ASAP ***

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