Employee Health Services
901 N.W. 17th Street, Miami, FL 33136
305-585-6903
JHS-ReturnToWork@jhsmiami.org

Healthcare Provider Evaluation Form

Return to Work Clearance

HEALTH CARE PROVIDER MUST PROVIDE RETURN TO WORK CERTIFICATION BY COMPLETING THIS FORM

Employee's Name: _____ Phone Number: _____ DOB: _____

Date medically clear to return to work: ____/____/____

Diagnosis or description of injury/surgery/illness: _____

Patient's return to work status:

[___] Return to full duty Date: ____/____/____

[___] Return to work with noted restrictions From Date: ____/____/____ To Date: ____/____/____

Detailed Restrictions: _____

_____

***If Restrictions, employee must be seen at the clinic**

MD Office Stamp

Health Care Provider's Signature _____

Print Name _____

Phone Number: _____ Date _____

Address City and State Zip: _____

EMPLOYEE HEALTH SERVICES USE ONLY

EHS Review Type: Clinic Visit [___] **Email:** [___]

Time Arrived: _____ **Time with Provider:** _____ **Time Discharged:** _____

Status Dates: Return to full duty on: _____ **R.A.C Referral:** _____

Discharge Instructions/Restrictions: _____

_____

Cleared to Return to Work: YES [___] **NO** [___] **Need to Follow-Up with EHS** [___]

Nurse Examiner Name/Signature: _____ **Date:** _____

Employee must complete:

I UNDERSTAND THE ABOVE INSTRUCTIONS AND MY RESPONSIBILITY FOR FULL COMPLIANCE:

EMPLOYEE SIGNATURE: _____ **Date:** _____

Supervisor Name: _____

Supervisor Phone: _____ **Email:** _____