Jackson HEALTH SYSTEM
Miracles made daily.

Employee Health Services

HR Connect - 901 NW 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: _____/_____/_____

[___] **No Open Wound/ No Drainage**

Detailed Restrictions:_____

_____

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

MD Office Stamp

Health Care Provider's Signature _____

License#: _____

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: _____