Essential Rheumatology LLC
860-325-6908

Return-to-Work Clearance Form

Patient Information

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____ Diagnosis/Condition: _____

Employer: _____ Job Title: _____

Work Clearance

☐ **Full duty — no restrictions**

☐ **Modified / light duty (see below)**

☐ **Not cleared to return to work at this time**

Effective Return Date: _____ Duration of Restrictions: _____

Restrictions (if applicable)

_____

_____

_____

_____

Follow-Up & Provider Certification

Next Appointment: _____ Re-evaluation Required: _____

I certify that the above-named patient has been evaluated and the information provided is accurate to the best of my clinical judgment.

Provider Name (Print): _____ Credential: _____

Provider Signature: _____ Date: _____