 **HARVARD - RETURN TO WORK FORM**

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical clearance date to return to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Please indicate specific date)**

\_\_\_\_\_\_ Regular Duty/ No Restrictions \_\_\_\_\_\_ No Driving (explain below)

\_\_\_\_\_\_ Modified Duty (explain below) \_\_\_\_\_\_ No Equipment Operation (explain below)

 \_\_\_\_\_\_ Reduced Hours (explain below) \_\_\_\_\_\_ Work Restrictions (explain below)

 \_\_\_\_\_\_ Duration of impairment (explain below)

 \_\_\_\_\_\_ Hours/Days (if restricted, what Days/Hours Per day)

**OTHER and/or Explanation from item(s) marked above** (including end dates, timeline etc.):

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit this form to FAS Human Resources by fax (617-495-4756) or email (leaves@fas.harvard.edu)**