

**REPORT OF INJURY OR ILLNESS ~
RETURN TO WORK SLIP**

Location	State	Dept	Phone
Employee Name	DOB		Date & Time of Incident
Address		City	State Zip
SS#	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Job Title		Hire Date	
Description of Incident:			

Employee Signature:	Date:
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Name of Employee: _____ is being referred to you for treatment.

Signed: _____ (Work Supervisor)

- May return to work _____
- No Limitation _____
- Light Duty for _____
- Limited lifting for _____
- Limited standing or walking for _____
- Limited stooping or bending for _____
- Limited use of "R" or "L" extremity for _____
- Other _____ Next Visit _____
- Referred to: _____

Physician

Date & Time

**This form is to be returned to your supervisor following receipt of medical treatment.
Attn: Supervisor, please send copy to Human Resources**