LIBERTY UNIVERSITY | HUMAN RESOURCES

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	☐ Yes ☐ No	Gender	☐ Male ☐ Female	
Job Title		Hire Date			
Description of Incident:					

Employee Signature:	**Date:**

✦✦✦✦✦✦✦✦✦✦✦ WORK STATUS ✦✦✦✦✦✦✦✦✦✦✦

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