LIBERTY UNIVERSITY™

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