REPORT OF INJURY OR ILLNESS ~
RETURN TO WORK SLIP

LIBERTY UNIVERSITY™

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