RETURN TO WORK PROGRAM
Important: Please email or fax completed form to the designated RTW contact on your HR Services Team.

Return to Work Referral Form

☐ **Initial** ☐ **Update**

Employee Information

Name:	Employee ID#:
Department Name:	Work Location:
Job Classification:	Employee Contact Number:
Date of Incident/Injury:	Supervisor Name:
First Day Off Due to Illness/Injury:	Supervisor Contact Number:
Anticipated Return Date:	
Employee's Work Restrictions:	
Additional Comments/Information:	
Form Completed by:	Contact Number:
Department & Title:	Date:

Please attach a copy of current doctor's note (if available)

To Be Completed by Workers' Compensation Division Only (if applicable)

Employee Status:	
Type of Injury:	
Medical Group/Treating Physician Name:	
Physician Address and Contact Number:	
Adjuster Name:	Date:
Additional Comments/Information:	
Workers' Compensation Claim Number:	

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