Western Wayne Medical Center

MEDICAL LEAVE – RETURN TO WORK FORM

PART I: PATIENT INFORMATION

Patient Name:	
DOB:	
Home Address:	
Phone:	

PART II: MEDICAL RETURN TO WORK CERTIFICATION (to be completed by the Health Care Provider)

Name of Health Care Provider:	
Name of Health Care Practice:	Western Wayne Medical
Address:	2280 Hwy 70 West, Goldsboro, NC 27530
Phone:	919.735.1400
Name of Patient:	
Date employee is released to return to work:	
Is the patient able to perform the essential functions of his/her position as of the return to work date?	☐ YES ☐ NO
Additional Comments:	
CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.	
Signature-Health Care Provider: **Date:**	