Return-to-Work Program

Miami-Dade Aviation Department

Physician's Work Status Form

Employee's Name: _____
Social Security #: _____
Date of Injury: _____
Current Office Visit:_____ **Time:** _____
Justification for the request:
_____
_____
_____
_____
_____

Expected Recuperative Duration: _____

Work Status:

☐ **Full Duty/No Limitations**

☐ **Modified Duty with the following restrictions:** _____

_____

_____

_____

_____

Doctor:
Address:
Telephone:
Fax:
Form Completed by: