Return-to-Work Weekly Progress Review

On a weekly basis, please complete the following information:

Employee Name: _____ Date: _____

1. Is the employee experiencing difficulty completing any work tasks due to his/her illness or injury since returning to work? ☐ No ☐ Yes, please explain:

2. Have medical restrictions changed since the beginning of the employee's return-to-work?
   ☐ No ☐ Yes, please describe:

3. Has the employee missed any time from work due to his/her illness or injury since returning to work? ☐ No ☐ Yes, please detail:

4. Do you or the employee have any suggestions for how we can further assist you with the employee's return-to-work? ☐ No ☐ Yes, please explain:

Comments or observations by employee:

Comments or observations by supervisor:

If the employee is experiencing problems in completing work tasks due to his/her illness or injury, the employee should discuss these issues with his/her healthcare provider.

Employee's Name	Employee's Signature	Date
Supervisor's Name	Supervisor's Signature	Date

Please return completed form to Human Resources for retention