OMA Physician Health Program

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RETURN TO WORK PLAN

Participant Name/ID:

Timeline (Input number of weeks)	**Work Hours** (Maximum not to be exceeded)	**Clinical Setting(s)**	**Comments**
Phase 1			
Phase 2			
Phase 3			
Phase 4			
Phase 5			
Call Shift Details (if applicable):			
Proposed RTW Start Date:			
Proposed RTW Review Date:			
Notes:			