



**Community Mental Health Program
Return to Work Recommendations – 0204A**

Claim Number

When the opportunity for return to work is identified, the psychologist should fill out the form below.

A. Injured or ill person information				
Last name		First name		
Address		City/Town	Province	Postal Code
Date of birth (dd/mmm/yyyy)		Date of Incident (dd/mmm/yyyy)		
By signing below, I am authorizing WSIB to provide my employer with this form related to my function abilities.				
Signature			Date (dd/mmm/yyyy)	

B. Health professional information			
Psychologist's name			
Facility name			
Address			
City/Town	Province	Postal Code	Telephone
WSIB provider ID		Your invoice number	
Date of visit (dd/mmm/yyyy)		Service code MHPRTW	
Complete these fields if HST is applicable to this form			
HST Registration number	Service code ONHST		HST amount billed \$

Last Name	First Name	Claim Number
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When the opportunity for return to work is identified, please provide a summary of the return-to-work recommendations that can be shared with the injured or ill person and their employer.

Regarding return to work, I recommend:

RTW - Full abilities OR RTW - With restrictions/limitations/accommodations		
1. Recommended restrictions/limitations/accommodations:		
2.		
3.		
4.		
5.		
Expected duration of restrictions/limitations/accommodations		
Psychologist's name	Signature	Date (dd/mmm/yyyy)