

# Return to Work - Medical Release Form

## Injury/Illness Overview

Employee / Patient Name: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Diagnosis or description of injury/illness:

\_\_\_\_\_  
\_\_\_\_\_

## The patients return to work status is (please select work status):

☐ Return to regular work, with no restrictions. Date: \_\_\_\_\_

☐ Able to return to work with noted restrictions. Date: \_\_\_\_\_

☐ Unable to return to work until the next evaluation. Date of next exam: \_\_\_\_\_

☐ Referred to another health care provider.

Referral provider: \_\_\_\_\_ Date of referred exam: \_\_\_\_\_

## Lifting Restrictions (please select restriction):

☐ None ☐ 10 – 19 lbs. ☐ 20 – 29 lbs. ☐ 30 – 39 lbs. ☐ 40 – 50 lbs.

## Additional Comments

\_\_\_\_\_  
\_\_\_\_\_

## Authorization

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address, City, State, and Zip: \_\_\_\_\_

Health Care Provider's Name: \_\_\_\_\_

Health care provider signature: \_\_\_\_\_



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