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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