WORK RELEASE FORM

This notice verifies that your
employee ____
was seen in this facility today (or on _______________ if checked [__]).
He/she may return to work on __________________ with the following restrictions:

None: [___]
No heavy lifting: [___] (over _____ pounds)
No prolonged standing: [___]
Desk Work Only: [___]
Other: [___] (described below)

These restrictions apply through _______________________________. After this date, your employee should be able to participate fully in work duties.

BE ADVISED: If symptoms continue and the employee is unable to perform the full duties of their job by this date, please advise the employee to make an appointment with your worker's comp physician. If that is not possible, the employee should see his or her own doctor or the referral doctor provided by us.

____
Physician or Nurse

NOTES:

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