

Authorization to Return to Work

Employee Section

Employee Name			
Employee Work Location			
Employee Position Title			
Employee Signature		Date	

Healthcare Provider Section

Healthcare Provider Name			
Phone Number			
Address			
City, State, Zip Code			

Date patient is released to return to regular duties: _____

I hereby certify that my patient is able to return to work without restrictions on the above indicated date.

Healthcare Provider Signature		Date	
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