

RETURN TO WORK RELEASE

1.) Client Name:

2.) Under Care from _____ to

3.) Nature of illness or injury

4.) Treatment Received:

5.) Current Medication:

6.) Specialized Treatment(s) Recommended:

7.) Restrictions:

May return to work _____ full day _____ half day

8.) Follow Up/Next Appt:

Physician's Printed Name
Date

Physician's Signature

Address

Phone

This form must be completed by the attending physician before a client may return to CFS following an extended or serious illness, or injury, or hospitalization.

Form # 5335

6/97