Internal Medicine/ Urgent Care/ Minor Trauma/ Occupational Medicine

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RETURN TO WORK/SCHOOL MEDICAL RELEASE

PATIENT'S NAME: ____:
PATIENT'S DOB: ____
DATE OF EXAM: ____

ACCOMPANYING PARTY NAME:____

___ THIS PATIENT HAS BEEN EXAMINED AND IS ABLE TO RETURN TO SCHOOL/WORK WITHOUT RESTRICTIONS

___ THIS PATIENT 'S FAMILY MEMBER WAS LATE OR WAS UNABLE TO RETURN TO WORK. *EXPLANATION, IF REQUIRED

___ THIS PATIENT IS UNABLE TO PERFORM ALL DUTIES
FROM: ____________________ TO: ____________________________

____ THIS PATIENT/FAMILY MEMBER MAY RETURN TO SCHOOL OR WORK ON

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_______ THIS PATIENT IS PERMITTED TO RETURN TO WORK PROVIDED THAT HE OR SHE IS RESTRICTED TO LIGHT DUTIES UNTIL FURTHER NOTICE.

*EXPLANATION, IF REQUIRED:
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