Disability Management Unit

877-443-6362

MEDICAL RELEASE TO RETURN TO WORK

To be completed by employee:

Patient/Employee Name: _____ Date of Birth: ____/____/____

Employee ID#: _____

The below information is required for our employee to return to work from a medical or maternity leave of absence.

To be completed by Health Care Provider:

Patient may return to work with **NO** restrictions on ____/____/____ (date)

Patient may return to work **WITH** restrictions on ____/____/____ (date)

Patient's restrictions will end on ___/____/____ (date)

DETAIL OF RESTRICTIONS_____

_____

_____

_____

_____ ____/_____/_____

Signature of Health Care Provider Date

_____

Health Care Provider Name and Business Address (please print)

_____ _____ _____

Type of Practice/Medical Specialty Telephone Number Fax Number

Fax Completed Form:
517-241-6898

5-24-2021