PHYSICIAN'S RETURN TO WORK AUTHORIZATION

____ ________________________

Patient's first and last name Occupation

Is a patient of mine and I have examined him / her on ______________________________

Month / day / year

Based upon my examination, my patient will be physically able to return to full duty without restrictions on: ____________________.

Month / day / year

COMMENTS: ____

____

Print Name (Physician):____

Signature of Physician or Practitioner: ____

Date: Office Phone No. ____

Type of Practice (Field of Specialization, if any):____________________________________

Return form to:
Human Resource Coordinator
Glenbard District 87
596 Crescent Blvd.
Glen Ellyn, IL 60137
Fax: 630-469-9107