



Employee's Doctor's Release Form

I, _____, hereby certify that _____,
Doctor's name Employee's name

who has been under my care for _____
Description of illness or injury

is now able to return to work and perform his/her duties with the following limitations;

for a period of _____ (months)(weeks)(days), until such time that he/she has received a full work release permit under my signature.

Doctor's Signature

Date