

# Work Release Form

Attention: Medical Provider

Modified work other than the patient's regular job may be available. To assist in restoring the patient's regular work and pay, please complete the information below

Patient's Name \_\_\_\_\_

Date of Injury/Illness \_\_\_\_\_

No Duty from \_\_\_\_\_ to \_\_\_\_\_

Modified Duty from \_\_\_\_\_ to \_\_\_\_\_

Return to Full Duty on \_\_\_\_\_

## Modified Duty Limitations Physical Limitations

No prolonged standing \_\_\_\_\_

No prolonged walking \_\_\_\_\_

No prolonged sitting \_\_\_\_\_

No knee bending, squatting, kneeling \_\_\_\_\_

Limited or no use of \_\_\_\_\_

Weight lifting restrictions \_\_\_\_\_

Keep affected area elevated \_\_\_\_\_

Keep dressing dry and clean \_\_\_\_\_

Use crutches/sling/splint \_\_\_\_\_

Other \_\_\_\_\_

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**List of prescribed medication and frequency of directed use**


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**Prescribed therapy and frequency**


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**Physician Comments:**


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**Physician's Signature** \_\_\_\_\_

By my signature, I have read, or had read to me, and fully understand the work restrictions as listed by the Physician.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reader/Interpreter Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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