**Work Release Form for Hospital**

### **Patient Details**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hospital ID (if applicable): \_\_\_\_\_\_\_\_\_\_\_**
* **Date of Admission: \_\_\_\_\_\_\_\_\_\_\_**
* **Date of Discharge: \_\_\_\_\_\_\_\_\_\_\_**

### **Medical Provider Information**

* **Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Attending Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hospital Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Work Release Authorization**

* **Condition Summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Recovery Status: Fully Recovered ☐ Partially Recovered ☐ Needs Follow-Up ☐**
* **Work Restriction: Yes ☐ No ☐**
* **Restricted Duties (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Physician Approval**

**I certify that the above patient is now fit/unfit for work with the mentioned limitations.**

**Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_**