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: _____