Work Release Form from Doctor Template

Patient Information

Full Name: _____
Date of Birth: _____
Address: _____
City/State/ZIP: _____
Phone Number: _____
Email: _____

Medical Certification

- **Doctor's Name: _____**
- **Clinic/Hospital Name: _____**
- **Diagnosis: _____**
- **Date of Treatment: _____**
- **Work Restrictions: _____**

Authorization

I, the undersigned, certify that the above-named patient is cleared to return to work.

Doctor's Signature: _____
Date: _____