

City of North Little Rock
Medical Release to Return to Work

WORKER'S COMP NON-WORKER'S COMP

This form must be completed and signed by the employee's treating medical provider. The employee must present completed and signed form to his/her supervisor following an absence due to injury or illness of three or more days.

Employee/Patient Name _____ Date _____

This is to advise that the above patient has been under my care and unable to work from:

_____ 201__ to _____ 201__.

Date of last exam/treatment: _____, 201__. Date of next exam/treatment: _____, 201__.

The employee/patient may now return to work: *(must be completed)*

- Without Work Restrictions (Full Duty)
- With Work Restrictions (Describe Below)

If returning with work restrictions, they are: *(must be completed)*

- Temporary. Date can reasonably be expected to return to full duty without restrictions _____
- Unable to determine at this time.
- Permanent

Will employee/patient require continuing treatment necessitating additional absences? Yes No.

If yes, How Often? _____ For How Long Required? _____

This form must be signed by the treating physician or other medical provider. Photocopies, stamped signatures, or signatures of any person other than the treating physician/medical provider are not acceptable.

TREATING PHYSICIAN/MEDICAL PROVIDER

Print Name: _____ Signature: _____ Date Signed: _____

Clinic Name: _____ Street Address: _____

City/State/Zip Code: _____ Phone Number: _____