Core MEDICAL GROUP
The Best in Healthcare Staffing

RETURN TO WORK RELEASE AUTHORIZATION

I, _____, (name)_____ (title)

do hereby authorize my physician or physician's office _____ to

release to Core Medical Group any information acquired in my recent medical examination.

Please check one:

☐ This was **NOT** a work related injury

☐ This **WAS** a work related injury that occurred on_____

I ***have*** ☐ or ***have not*** ☐ completed the proper incident form as outlined in my employee handbook.

_____ _____

Signature Date

PHYSICIAN'S STATEMENT

Date of Examination: _____

I have examined _____, and
to the best of my knowledge, he/she is in good physical and mental health and is fit to work as
_____ (patient title).

☐ **without** restrictions or limitations.

☐ **with** restrictions or limitations as detailed below (Please check all that apply with maximum expectation limit)

☐ *Lifting* ____ *lbs* ☐ *Standing* ____ ☐ *Bending* ____ ☐ *Pushing/Pulling* _____

☐ *Other*_____

Restrictions:_____

Duration/Expiration of Restrictions:_____

Follow-Up Instructions/Appointments (if applicable):_____

_____

Signature of Physician/Physician's Assistant/Nurse Practitioner (Circle One) Date

_____

Printed Name of Physician/Physician's Assistant/Nurse Practitioner (Circle One) Practice/Clinic Name

_____

Address Phone Number