



## RELEASE TO RETURN TO WORK

**We must receive this form prior to the day you return to work.**

Patient's Name: \_\_\_\_\_

Date Patient was last seen: \_\_\_\_\_

This is to notify the College that my patient, \_\_\_\_\_,

is released to return to work on \_\_\_\_\_.

Full Duty without restrictions

Light Duty with restriction: Please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Anticipated Length of Restriction(s): \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Health Care Provider:**

When this form is completed, it can be faxed to the attention of Joe Kolakowski, Director of Benefits, Community College of Philadelphia, at 215-972-6307.