

RETURN TO WORK RELEASE FORM

Instructions:

Employee: Have your health care provider complete this form prior to your return to work. Return the completed form to Benefits@IPGpet.com before you return to work.

Health care provider: Please complete this form, and return it to the patient.

Employee name: _____

Job title: _____

Date the condition began: _____

Please check one of the following:

- ☐ The employee is able to work a full, regular schedule with no restrictions, beginning _____ (date).
- ☐ The employee is able to return to work with restrictions from _____ (date) through _____ (date).

Please indicate restrictions, if any, below:

Health care provider's signature: _____

Health care provider's printed name: _____

Health care provider's contact information: _____

Date: _____