Date: ______________
Injured Worker Name: ______________
Claim Number: ______________

## RETURN TO WORK AUTHORIZATION
## DISABILITY CERTIFICATE

____ The injured worker is medically and physically able to perform work without restrictions effective ______________

____ The injured worker is released for light duty/modified work with the following restrictions: ______________

Anticipated duration of disability is ______________

Please provide the objective medical findings to support disability. *This is required*: ______________

____ The injured worker is not released to any type of work based on the following: Please provide the objective medical findings to support disability. *This is required*: ______________

Anticipated duration of disability is ______________

The injured worker requires further treatment ____ Yes ____ No
Diagnosis of all work related conditions are: ______________

Next appointment date ______________

Comments: ______________

Physician Signature ______________ Print Name ______________

Date: ______________ Phone Number ______________

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