

STATE DISABILITY INSURANCE (SDI)

Physician Medical Release & Return to Work Certification

PHYSICIAN / CLINIC INFORMATION

Facility/Clinic Name

Physician/Provider Name & Title

Address

Phone / Fax Number

PATIENT INFORMATION

Patient Full Name

Date of Birth

SDI Claim / Member ID Number

Employer Name

MEDICAL RELEASE STATUS

☐

Full Release: The patient is released to return to full, unrestricted work duty.

Effective Date: _____

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Modified Duty Release: The patient may return to work with the restrictions listed below.

Effective Date: _____

Estimated End Date: _____

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Unable to Return: The patient remains totally disabled and unable to return to work.

Estimated Re-evaluation Date: _____

WORK RESTRICTIONS (FOR MODIFIED DUTY)

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No lifting, carrying, pushing, or pulling over _____ lbs.

☐

No repetitive bending, twisting, or squatting.

☐

No prolonged standing (limit to _____ hours/day).

☐

No prolonged sitting (limit to _____ hours/day).

☐

No repetitive typing, grasping, or fine manipulation.

☐

No driving / operating heavy machinery.

☐

Rest breaks required: _____

☐

Other: _____

ADDITIONAL COMMENTS / MEDICAL DETAILS

PHYSICIAN CERTIFICATION & SIGNATURE

I hereby certify that the above medical information is true and accurate based on my evaluation of the patient. I license and authorize the release of this information for State Disability Insurance administration and employment accommodation purposes.

Physician Signature

Date

State License Number

NPI Number