

STATE DISABILITY INSURANCE CLAIM

Physician's Return to Work Release / Certification

1. PATIENT / CLAIMANT INFORMATION

FULL NAME

DATE OF BIRTH

CLAIM NUMBER (IF APPLICABLE)

SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

2. DISABILITY AND RELEASE STATUS

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Full Release (No Restrictions): The patient is released to return to full, unrestricted work duty effective on

_____.

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Modified Release (With Restrictions): The patient is released to return to work with the restrictions detailed below, effective from

_____ through _____.

3. SPECIFIC WORK RESTRICTIONS (IF APPLICABLE)

PHYSICAL LIMITATIONS (E.G., LIFTING LIMITS, STANDING LIMITS, REPETITIVE MOTIONS)

MAXIMUM HOURS ALLOWED PER DAY

MAXIMUM DAYS ALLOWED PER WEEK

4. MEDICAL PROVIDER CERTIFICATION

PROVIDER NAME

LICENSE NUMBER / SPECIALTY

FACILITY ADDRESS & PHONE NUMBER

SIGNATURE OF ATTENDING PHYSICIAN / PRACTITIONER

Original signature required (no stamps)

DATE