GEORGIA DEPARTMENT OF HUMAN SERVICES

RELEASE TO RETURN TO WORK

_____ is released to return to work on _____
[Name of Employee] [Date]

☐ With no work-related restrictions

OR

☐ With the following work-related restrictions: _____

_____

_____

_____

_____

_____

Duration of restrictions: _____

_____

_____ _____
[Name of Attending Health Care Provider - Please Print] [Type of Practice]

_____ _____ _____
[Signature of Attending Health Care Provider] [Phone Number] [Date]