Community College of Philadelphia

RELEASE TO RETURN TO WORK

We must receive this form prior to the day you return to work.

Patient's Name: ____

Date Patient was last seen: ____

This is to notify the College that my patient, ______________________________,

is released to return to work on ______________________________.

☐ Full Duty without restrictions

☐ Light Duty with restriction: Please describe ______________________________

____

____

____

Anticipated Length of Restriction(s): ____

Physician's Name: ____

Physician's signature: ____

Telephone Number: ____

Fax Number: ____

<u>Health Care Provider:</u>
When this form is completed, it can be faxed to the attention of Joe Kolakowski, Director of Benefits, Community College of Philadelphia, at 215-972-6307.