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RELEASE FOR WORK AUTHORIZATION

***NOTE: This form must be returned to Supervisor
within 24 hours of doctor appointments.***

Employee Name: _____ Appointment Date: _____

Job Title: _____

Diagnosis: _____

NOTE TO HEALTH CARE PROVIDER:

CRISTA Ministries often has light duty work available for temporarily disabled workers. We are able to accommodate a wide range of physical restrictions. Please indicate approval below and provide release dates, if appropriate for this injured worker.

◆ Worker released to FULL duty? Yes No If yes, effective when? _____

◆ Approved for LIGHT duty? Yes No If yes, effective when? _____

◆ What restrictions, if any, are in effect for this employee? _____

◆ Anticipated date that restrictions may be removed? _____

◆ *If employee cannot be released to work light duty, please explain:* _____

◆ Is further treatment necessary? Yes No

◆ Next appointment date: _____

Employee's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____ Phone # _____