

PHYSICIAN'S NOTICE OF RELEASE TO WORK

Submit to insurer within three (3) days of release to work
with a copy to the employee and his or her attorney.

DWC/MAB File # _____

Insurer's File # _____

Employee/Patient Information:

Social Security # _____

Name _____

Address _____

City, State, Zip _____

Phone _____

Date of Birth _____

Injury Date: _____

Insurance Carrier:

Name _____

Address _____

City, State, Zip _____

Phone _____

Employer Information:

FEIN # _____

Name _____

Address _____

City, State, Zip _____

Phone _____

Adjusting Company:

Name _____

Address _____

City, State, Zip _____

Phone _____

If the insurer is not known, contact the Division of Workers' Compensation at (401) 462-8100.
Section 28-33-8(b) of the RI Workers' Compensation Act provides for a \$20.00 fee to be charged for the
timely filing of this form.

This medical report is rendered pursuant to Section 28-33-8 of the RI Workers' Compensation Act.

This is to certify that the above named employee is able to return to work on _____

To (check one) Regular duty, no restrictions Modified duty, limitations as follow:

Indicate modified duty restrictions:

No operating heavy machinery or vehicles

Alternate standing/sitting

No repetitive climbing ladders or stairs

No work involving use of right/left _____

May lift up to _____ pounds only

Sit down work only

No reaching above shoulders

Keep wound clean and dry

No repetitive twisting, bending, squatting

Other _____

No repetitive stooping, kneeling _____

The patient will require no further medical items or medical services associated with this claim.

This certification is based on the medical examination performed on _____

Physician's signature _____ Date _____

Physician's name _____

Treatment facility _____

Physician's Assistant Signature _____

Supervising Physician's Name _____

Physician's Address _____