

TOWN OF NISKAYUNA

RELEASE TO WORK STATEMENT

I have reviewed the attached job description for the title _____

and I agree that _____
Patient/Employee Name

can return to work on _____ with / without (CIRCLE ONE) restrictions.
Date

Please specify all restrictions below including, but not limited to, hours of work per day and week, lifting limits or specific restrictions of movement. Please print clearly.

Doctor's Name (Please print)

Doctor's signature

Doctor's phone number

Date