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: _____

Employer Information:

FEIN # _____
Name _____
Address _____
City, State, Zip _____
Phone _____

Insurance Carrier:

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
- ☐ No repetitive climbing ladders or stairs
- ☐ May lift up to _____ pounds only
- ☐ No reaching above shoulders
- ☐ No repetitive twisting, bending, squatting
- ☐ No repetitive stooping, kneeling
- ☐ Alternate standing/sitting
- ☐ No work involving use of right/left _____
- ☐ Sit down work only
- ☐ Keep wound clean and dry
- ☐ Other _____

_____

☐ 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 _____