

McLaren Family Medicine Residency

**VERIFICATION OF OFFICE VISIT
RETURN TO WORK/SCHOOL STATEMENT**

Date: ____ / ____ / ____ Patient name: _____

Employer/School (name): _____

The above named patient may return to work/school on: ____ / ____ / ____

Work status:

- Full duty
- Light duty
- No work

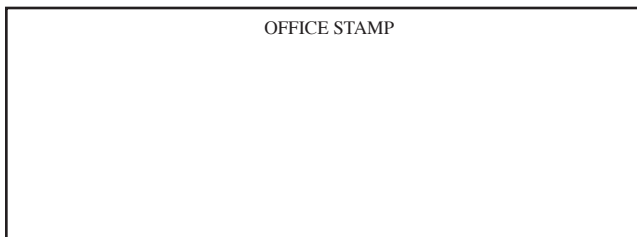
Restricted activity:

- Yes
- No

Comments: _____

Sincerely,

_____ D.O. / M.D.



**VERIFICATION OF OFFICE VISIT
RETURN TO WORK/SCHOOL STATEMENT**

Patient Name:
Date of Birth: