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

White — PATIENT COPY
Yellow — MEDICAL RECORDS

M-3379-A (12/14)

Patient Name:

Date of Birth: