

McLAREN FLINT  
Flint, Michigan

**WORK/SCHOOL RELEASE FORM**

Patient name: \_\_\_\_\_

Patient date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient address: \_\_\_\_\_

May return to work/school (circle one) on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

May not return to work/school

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time: \_\_\_\_\_



PT.

MR.#/P.M.

DR.