

# Release for Work Authorization



Snohomish County

Risk Management Division ♦ 3000 Rockefeller Ave., M/S 610 ♦ Everett, WA 98201-4046 ♦ (425) 388-3475

Department/Division

Claim Number

**This form must be completed to enable the claimant to return to work**

Dear Physician:

Snohomish County is a self-insured employer with a Return To Work Program. We are willing to modify the injured worker's job to meet their medical or physical limitations. When necessary, transitional work assignments may also be available. Please be specific as to the injured worker's limitations so we may take the appropriate action. THANK YOU.

Employee's Name

Job Title

Date of Injury/Illness

## Physician's Findings and Recommendations

Diagnostic impression: \_\_\_\_\_

Is the employee authorized to return to work? Date authorized to return \_\_\_\_\_

\_\_\_\_\_ Yes, with no restrictions.

\_\_\_\_\_ Yes, with the following medical or physical restrictions: \_\_\_\_\_

Anticipated date restrictions may be removed? \_\_\_\_\_

\_\_\_\_\_ No, Employee is unable to return to work because \_\_\_\_\_

Is employee authorized time loss"? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is the injured employee's time loss the direct result of the work-related injury?

\_\_\_\_\_ If yes, estimated number of disabling days: \_\_\_\_\_

\_\_\_\_\_ No

Is further treatment necessary?

\_\_\_\_\_ Yes. Next follow-up treatment: \_\_\_\_\_

Name of treating Physician

Phone Number

Signature of treating Physician

Date

Employee's Signature

Date

Supervisor's Signature

Date