

Doctor Release for Employment and/or Training

Doctor's Name: _____

Date of Visit: _____

Location/Office Address: _____

(Please attach a business card for verification)

Patient Name: _____ DOB: _____ Gender: _____

Occupation: _____

I have evaluated patient's physical abilities and limitations relating to his/her *Injury / Disability*
(Circle one)

and hereby issue the following determination(s):

- Release patient to full-time employment/training with **no** restrictions or limitations.
- Recommend retraining as disability/injury will be aggravated by or prohibits patient from continuation of current career/occupational field.
- Release patient to employment/training with the following limitations or restrictions (Please mark all that apply):
 - Limited Time: No more than _____ hours per *day* or *week*.
(Circle one)
 - Restricted to Limit: *Standing* *Sitting* *Walking* *Repetitive Movement(s)* *Other*
(Circle all that apply)

Define and specify limitation (e.g. limit repetitive movement of wrist as in typing):

How much weight is patient able to lift frequently?

- 0-10 pounds
- 11-20 pounds
- 21-50 pounds
- 51+ pounds

Lift occasionally?

- 0-10 pounds
- 11-20 pounds
- 21-50 pounds
- 51+ pounds

- Restrictions are considered to be: Temporary (lasting 6 months or less)
 Long-Term (6 months or greater depending on treatment)
 Permanent

(Doctor's Signature)

(Date)

Please return form to patient to submit to:
FIT for an Independent Tomorrow
Attention: NAME

1785 E. Sahara Ave. Suite 160 ~ Las Vegas, Nevada 89104
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