

BACK TO WORK/SCHOOL NOTE

_____ was seen in the Emergency Department
of _____
(Name)

_____ on _____
_____.
(Hospital Name) (Date)

WORK: He/she:

- May return to work immediately:
- At full capacity.
- On light duty until _____.

*Describe light duty:

- No lifting objects over _____ pounds.
- No bending.
- No pushing/pulling with _____ arm(s).
- No prolonged standing or walking.
- Other: _____

SCHOOL: He/she:

- May return to school immediately.
- May return to school on _____
- May participate in gym and sports.
- May not participate in gym and sports until _____
- Must take prescribed medication in school for _____ days.

COMMENTS OR OTHER SUGGESTIONS:

Signature of Physician/Nurse: _____