MEDICAL RELEASE FORM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(to be completed by employee)

I, _____, in order to verify my ability to return to duty and perform (or not perform) the duties of my position, do hereby authorize my physician, _____ to release the medical information requested below.

Mail completed document to:

Dept. of Culture, Recreation and Tourism
ATTN: Human Resources Director
P. O. Box 94361
Baton Rouge, LA 70804-9361

_____ _____

Employee's Signature Date

EMPLOYEE'S JOB INFORMATION

(to be completed by supervisor)

Employee_____DOB_____

Job Title_____

Duties_____

_____

_____

PHYSICIANS' REVIEW AND STATEMENT

(to be completed by physician)

1. The above referenced employee has been seen by me for a medical condition from_____ through _____.

2. Date of last professional consultation _____

3. Prognosis _____

4. Based on my knowledge of this employee's medical condition, the employee is:

   ___(a) medically able to competently and safely perform the duties described above and can return to work on a regular basis on _____.

___(b) medically unable to competently and safely perform the assigned duties as described above.

___(c) medically able to return to work on _____ to perform modified duties, including the following restrictions and limitations:

_____

_____

_____

___(d) an updated evaluation, to be conducted on _____, is required before this employee can be permitted to return to work.

5. Additional comments:

_____

_____

_____

Please print physician's name and address:

_____
Physician's Name

_____
Address

_____ _____
City/State Telephone #

Certified by:

_____ _____
Physician's Signature Date