

**MEDICAL RELEASE
FITNESS FOR EMPLOYMENT / ENROLLEMENT FORM**

Patient Name: _____

Social Security Number: _____

The above mentioned patient has been under my care from _____ until _____
(Date) (Date)

**PLEASE SIGN OR WRITE IN N/A ON EACH AND SIGNATURE LINE.
PLEASE DO NOT LEAVE ANY LINES BLANK**

The above named individual is medically, physically and psychologically fit to perform their work/school duties, return to work / school, is currently not gravely disabled, posing any health / safety risk to them self or others, and is not in need of on going treatment.

Treating Physician or therapist signature

Date

The above named individual is medically, physically and psychologically fit to perform their work/school duties, and to return to work / school with the following considerations.

It is the opinion of this treating physician / therapist the above named individual needs to remain in follow-up treatment in order to resume their work/school responsibilities in a manner that they will not pose any health / safety risks to them self or others, and/or in order for them not to become gravely impaired. (Please attached a copy to the follow-up treatment plan)

Treating Physician or therapist signature

Date

It is the opinion of this treating physician / therapist the above named individual has an impairment(s) which requires modifications to their job/school responsibilities. Attached is a written, signed and dated report and/or medical examination which explains the work / school limitations which are recommended and the time period which these work modifications will need to be adjusted for.

Treating Physician or therapist signature

Date

Physician or therapist name (Please print): _____

Address: _____

**Please return to: LSUHSC Campus Assistance Program
1542 Tulane Ave. Box E 5-4
New Orleans, LA 70112**