Return to Work Release Form

Counselor Participant Name:_____License #:_____
(Print or type client's/patient's name)

Case Manager:_____Case # _____

The above counselor has been under my/our care since_____/_____/_____.
(month) (day) (year)

He/she is safe to be released to return to work **in counseling** as of_____/_____/_____,
(month) (day) (year)
provided the counselor is compliant with return to work guidelines.

Anticipated date of discharge_____/_____/_____
(month) (day) (year)

Healthcare Provider comments or **conditions to release**, if any: _____

_____

_____

Is there any reason the counselor should not work nights? Yes____ No____ (if Yes, explain)_____

_____

_____

Continuing Care Plan: _____

_____

Name & Credentials of Healthcare Provider: _____
(PLEASE PRINT)

Name of Treatment Program/Hospital _____

Address:_____City_____State_____Zip code_____

Phone number :(_____)_____email: _____

_____**Date:**_____
(Signature of Provider)