

## 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: \_\_\_\_\_

\_\_\_\_\_  
**(Signature of Provider)** Date: \_\_\_\_\_