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|-----------------|
| Doctor: |
| Address: |
| Address: |
| Phone: |

RETURN TO WORK

| |
|--------------|
| Date: |
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| <i>This certifies that:</i> |
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| |
|--|
| <i>has been under my professional care for</i> |
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|---|
| <i>and is cleared to return to work on:</i> |
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| <i>Notes:</i> |
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Signature _____