



Manchester Public Schools
 Human Resources Office
 45 North School Street
 Manchester, CT 06042
 Tel: (860) 647-3327 / Fax: (860) 647-3327

DOCTOR'S DISABILITY RELEASE FORM

EMPLOYEE	Name of Employee (Please Print or Type):	
	Employee's Occupation/Job Title:	
	<i>I authorize release of the information below and any related medical records to Manchester Public Schools and its authorized representatives.</i>	
	Employee's Signature:	Date:

HEALTH CARE PROVIDER	<i>THE FOLLOWING MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES PRIOR TO THE RETURN TO WORK DATE.</i>		
	Date of Exam/Treatment:		
	Nature of Injury/Diagnosis:		
	Treatment Administered:		
	The above-named individual is released to return to work effective: _____ (Date)		
	Are There Restrictions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Until _____ (Date)
	Please Describe Restrictions, if Any:		
	Name of Health Care Provider:		
	Specialty:		
	Address:		
	City:	State:	Zip:
Telephone Number:			

<i>Signature of Health Care Provider:</i>	<i>Date:</i>