GOVERNMENT OF BERMUDA

Ministry of Public Works

**Department of Finance & Administration**

Return to: Safety and Health Officer, Post Office Building (3rd floor), 56 Church Street, Hamilton HM 12, Tel: (+1 441) 297-7842 Email: dwsimmons@gov.bm

# Occupational Health Program: Physician Release Form

***The following section is to be completed by the employee (Please Print).***

Employee Name: _____

Job Title: _____

Department/Section: _____ Supervisor: _____

Date of Birth: _____ (MM/DD/YYYY) Sex (check one): Male__ Female__

Tel. # _____ Email: _____

***The following section is to be completed by the examining physician.***

This is to certify that on this date _____, I have examined the above named person, and based on my findings, have determined that this individual (check one) **may** __ **may not** __ perform his/her required work.

Identify any limitations on required work: _____

_____

If a follow-up medical evaluation is required, date: _____

Examining Physician (print): _____

Examining Physician (signature): _____

Address: _____

_____

Phone: _____

Date: _____

Copy to employee: _____ (MM/DD/YYYY)

Copy to employer: _____ (MM/DD/YYYY)