TRISTAR

AUTHORIZATION TO RETURN TO WORK

First Name:	Last Name:
First Day Missed:	Last Day Worked:
Employer Name:	

COMPLETE THE FOLLOWING STEPS:
STEP 1: Complete all of the information above.
STEP 2: Give this document to your Health Care Provider and instruct him/her to complete.
After your Health Care Provider has completed and signed this form,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail the form to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

You will not be allowed to return to work until TRISTAR has received this completed form.

INSTRUCTIONS TO HEALTH CARE PROVIDER: *Complete and return to your patient or to TRISTAR directly as instructed above.*

This individual is currently under our professional care.

The patient is released to work as of the following date: _____

Please check one of the following:

☐ The patient is released to work without restrictions.

☐ The patient is released to work with the following restrictions and/or limitations.
From _____ (date) through _____ (date)

Please describe in detail restrictions and/or limitations below:

_____

_____

_____

_____

_____

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of Health Care Provider: _____ Date: _____

Address of Health Care Provider: _____

Office Phone: _____ Office Fax: _____

Signature of Health Care Provider: _____