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Bone and Joint Surgery Center
4245 Roosevelt Way NE
Seattle, WA 98105-6920
(206) 598-4288

Patient Name:_____

Patient Claim#:_____

Patient U#:_____

To Whom It May Concern:

_____was seen in the Bone and Joint Surgery Center on _____

for Follow up for shoulder_____.

The patient

- ☐ May return to work/school on _____(Date)
- ☐ Full duty-no restrictions
- ☐ Modified duty with the following restrictions:_____

  _____
- ☐ May not return to work/school until the following date:_____

The patient should return for clinic evaluation:_____

Physician's Signature_____

Physician's Name (Please Print)_____