

MURPHY OIL USA
Superior Refinery
Superior, Wisconsin

AUTHORIZATION TO RETURN TO WORK

(If not signed personally by doctor, name and title of person signing for the doctor must also be shown.)

This is to certify that _____ has
Patient's name

Been disabled with _____ and it has been impossible or undesirable for him/her to carry on his/her regular duties while under my care.

I last saw him/her in my office, or at his/her home, or at a hospital on the following date:

In my opinion this employee has sufficiently recovered to the extent that it is reasonably safe for him/her to perform those duties assigned to him/her prior to his/her disability without aggravating his/her condition, and return to work on _____

Signed _____ M.D.

Address _____

Date _____

Noted by Supervisor _____ (add remarks if appropriate)
