MEDICAL AUTHORIZATION TO RETURN TO WORK FORM

(From Employee Long-Term Health Leave)

Medical Authorization to be provided Prior to Return to Work

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	M.I.	EMPLOYEE #

SCHOOL/DEPARTMENT

PRINCIPAL/SUPERVISOR'S NAME	SCHOOL/DEPARTMENT

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S NAME	PHYSICIAN'S PHONE NUMBER	PHYSICIAN'S FAX NUMBER

MEDICAL CLEARANCE TO RETURN TO WORK ON DATE: _____

_____ Regular Duty/ No Restrictions

_____ Modified Duty (explain below)

_____ Reduced Hours (explain below)

_____ Hours/Days (if restricted, what Days/Hours Per day)

_____ No Driving (explain below)

_____ No Equipment Operation (explain below)

_____ Work Restrictions (explain below)

OTHER and/or Explanation from item(s) marked above:

_____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

Return Form to:

Seattle Public Schools
Human Resources - Leave Office, MS 33-380
PO Box 34165, Seattle, WA 98124-1165
Fax 206-252-0021