

Certification of Health Care Provider

RELEASE TO RETURN TO WORK

CHECK HERE IF JOB DESCRIPTION IS ATTACHED

CHECK HERE IF THIS IS A SAFETY SENSITIVE POSITION

EMPLOYEE NAME: _____

To be completed at final visit before release:

RETURN TO WORK STATUS:

- Able to resume regular duties as of _____
- Unable to return to work for approximately _____ more days. Projected RTW date: _____.
- Able to return as of _____ but only part time.
of hours/wk _____
- Unable to return to work indefinitely
- Able to return as of _____, but light duty with restrictions. (See Below):

RESTRICTIONS/LIMITATIONS:

- Limited Walking _____
- Lifting to _____ lbs. only
- Limited Climbing _____
- Limited use of Left arm/hand _____
Right arm/hand _____
- Limited ending/Stooping/Kneeling _____
- Limited Operating vehicle/machinery _____
- Limited Standing _____
- Other: _____
- Limited Sitting _____
- Other: _____
- Limited Overhead Working _____
- Other: _____

Return visit necessary: Yes No If yes, when: _____

Additional Comments: _____

Physician Signature

Date

Physician Name (Please Print)

Physician Phone Number

Please Send Completed Form To:

ATTN: Sheri Thompson / Human Resources
Houston County Commission; P.O. Box 6406; Dothan, AL 36302
(334) 677-4778
May be faxed to: (334) 677-4779