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 _________________
☐ Able to return as of ____________ but only part time.
   # of hours/wk ____________
☐ Able to return as of ____________ but light duty with restrictions. (See Below):

☐ Unable to return to work for approximately _________ more days. Projected RTW date:__________.
☐ Unable to return to work indefinitely

REstrictions/Limitations:

☐ Limited Walking ________________________________
☐ Limited Climbing ________________________________
☐ Limited ending/Stooping/Kneeling __________________
☐ Limited Standing ________________________________
☐ Limited Sitting _________________________________
☐ Limited Overhead Working ________________________

☐ Lifting to ______________________ lbs. only
☐ Limited use of Left arm/hand ________________
   Right arm/hand ________________
☐ Limited Operating vehicle/machinery________________________
☐ Other: __________________________________________
☐ Other: __________________________________________
☐ 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