Medical Authorization to Return to Work Form

(from employee long-term health leave)

Medical authorization to be provided prior to return to work.

Employee Information

Last Name: _____ First Name: _____

Middle Initial: _____ Employee Number: _____

School/Department Info

Principal or Supervisor Name: _____

School or Department Name: _____

To be Completed by Physician

Physician Name _____

Physician Phone Number _____ Physician Fax Number _____

Date employee is medically cleared to return to work: _____

- ☐ 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 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