RETURN TO WORK CERTIFICATION

EMPLOYEE

Employee Name:

Department:

Position:

Supervisor:

HEALTH CARE PROVIDER

PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO HUMAN RESOURCES PRIOR TO THE RETURN TO WORK DATE.

Please review the attached job description.

☐ Yes ☐ No ☐ Yes, with restrictions or accommodations

Please list any restrictions or describe accommodations including schedule changes which the department should consider.

Are the restrictions: ☐ Permanent ☐ Temporary, **until (date)**: _____

Lifting ☐ 0-10 pounds ☐ 10-20 pounds ☐ 20-50 pounds ☐ 50-100 pounds

Bending _____ Kneeling _____ Stooping _____

Twisting _____ Standing _____ Walking _____

Sitting _____ Climbing _____ Reaching _____

Repetitive Motion _____ Grasping _____ Cognitive _____

Other _____

_____

Comments:

Employee is released to return to work effective (date):

Name of Health Care Provider:

Specialty: Phone number: Fax number:

Address of Health Care Provider:

_____

Signature of Health Care Provider Date

OKCPS HR Benefits Contact Information:

Fax number: 405.587.0148

Phone number: 405.587.0801