CERTIFICATION BY A HEALTH CARE PROVIDER FOR RETURNING TO WORK

1. Employee Name: _______________________________________________________
   (please print)

2. Date the employee may return to work: ______________________________

3. List below any restrictions or accommodations that are necessary and related to the employee’s work:

4. Employee’s signature: _______________________________ Date: ___________

5. Signature of health care provider: _______________________________ Date: ___________