Livingston EDUCATIONAL SERVICE Agency

RETURN TO WORK CERTIFICATION

Have your health care provider review your attached job description and ask him/her to complete this form. Return the completed form to Jenn Damon in the Human Resources Department **prior to your return to work**.

Employee name: _____

Department: _____

Date the condition began: _____

Please check one of the following:

☐ The employee is able to work a full, regular schedule with no restrictions, beginning _____ (date).

☐ The employee is unable to return to work until _____ (date).

☐ The employee is able to return to work on a reduced schedule for _____ hours a day from _____ (date) through _____ (date).

☐ The employee is able to return to work with restrictions from _____ (date) through _____ (date).

Please indicate restrictions, if any, below for:

Standing (number of hours): _____

Walking (number of hours): _____

Sitting (number of hours): _____

Lifting (number of pounds): _____

Carrying (number of pounds): _____

Use of hands (repetitive motions, pushing, pulling): _____

Any other restrictions: _____

Signature of Health Care Provider: _____

Printed Name of Health Care Provider: _____

Date: _____