Please complete and return to:
Harford County Public Schools ✧ HR-Benefits Office
102 S. Hickory Avenue, Bel Air, MD 21014
Phone: 410-588-5275 Fax: 410-588-5316

Return to Work Medical Certification Form

This form is to be completed **when you have been released** by your physician to return to work from your medical leave. You must have your healthcare provider certify that you are able to return to work and the effective date. You will **NOT** be permitted to resume work until your healthcare provider certifies that you are able to perform the essential functions of your job. **Return this form to the Benefits Office at least two business days PRIOR to your scheduled return to work date.**

To be completed by EMPLOYEE:

Employee Name: _____ Employee #: _____

Location/School: _____ Job Title: _____

Date leave began: _____/_____/_____ Returning to work on: _____/_____/_____
(the actual date that you will return to work)

Employee's Signature: _____ Date: _____

All questions below to be completed by HEALTHCARE PROVIDER:

I certify that _____ is able to perform the
Employee's Name

essential functions of his/her job: **without** restrictions effective _____/_____/_____.

with restrictions effective _____/_____/_____.

If restrictions apply – describe limitations (including, but not limited to, weight bearing, lifting, any assistive devices such as a walker, scooter and/or other supports such as cast, sling, post-op shoe, cast boot, etc.):

_____

_____

_____

Restriction(s) are to be in place from: _____/_____/_____ to _____/_____/_____

Healthcare Provider's Name: _____

Telephone: _____ Address: _____

Signature:_____ Date: _____
Healthcare Provider's Signature - Stamp or designee signature NOT ACCEPTABLE.