North Point Educational Service Center

RETURN TO WORK CERTIFICATION

Employee's Name: _____ Position: _____

Building: _____

Employee's serious health condition which caused him/her to take leave:
_____
_____

Date leave commenced: _____

Date leave is set to end: _____

Name of treating health care provider:_____

Medical practice (field of specialization, if any):_____

THE EMPLOYEE IS ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER JOB, WITH OR WITHOUT A REASONABLE ACCOMMODATION. **YES NO**

Any restrictions or accommodations necessary to allow the employee to return to work:
_____
_____
_____
_____

_____ _____
Health Care Provider's Signature Date

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH AS REQUIRED BY THE AMERICANS WITH DISABILITIES ACT.