MONTOUR SCHOOL DISTRICT

www.montourschools.com

EMPLOYEE REINSTATEMENT/RETURN TO WORK FORM

THIS FORM IS TO BE COMPLETED BY THE PHYSICIAN

_____ _____

PRINT EMPLOYEE'S NAME D.O.B.

Has my permission to return to work on _____. He/She has been under my
MONTH DAY YEAR

care for the following: _____

_____

_____.

He/She is subject to the following work limitations/restrictions: PLEASE NOTE: This line must be completed. If there are NO LIMITATIONS/RESTRICTIONS, it must be indicated below as "NO RESTRICTIONS OR LIMITATIONS."

_____

_____

_____

These work limitations/restrictions should be in effect until: _____
MONTH DAY YEAR

Comments: _____

_____

_____

***IF THIS FORM HAS BEEN COMPLETED BY ONE OF THE FOLLOWING, THE SUPERVISING/COLLABORATING PHYSICIAN MUST SIGN HERE TO VERIFY THE ACCURACY OF THE INFORMATION ON THIS FORM: MEDICAL DOCTOR IN TRAINING (MT); CERTIFIED NURSE MIDWIFE (CNM); PHYSICIAN'S ASSISTANT (PA-C); DOCTOR, NURSE PRACTITIONER (DNP), AND CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP).**

X_____ X_____

Signature of Health Care Provider Signature of Supervising/Collaborating Physician

_____ _____

Print/Type Name Print/Type Name

_____ _____

Date Date

_____ _____

Address & Zip Code Address & Zip Code

_____ _____

Phone Phone

_____ _____

Fax Fax