Return to Work Authorization Form

To be completed by a licensed health care provider releasing the employee to return to work following a medical absence.

TO BE COMPLETED BY EMPLOYEE

First Name: _____ Middle Initial: _____ Last Name: _____

Note to Employee - If you believe you have a medical condition that is affecting your ability to perform the essential functions of your job and require an accommodation under the Americans with Disabilities Act, please contact the Director of Human Resources at (847) 949-2200 X1208 or by emailing smccreery@d120.org.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Provider's Name: _____

Provider's Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: (____) _____ Fax: (____) _____

The individual listed above has been released to:

◯ Return to work full duty with no work restrictions as of this date _____ / _____ / 20_____

◯ Return to work **WITH** the following restrictions:

_____

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

Return this completed form to District 120 Human Resources, 1500 West Hawley Street, Mundelein, IL 60060