



LOMPOC UNIFIED SCHOOL DISTRICT
 Certificated Human Resources
 1301 North A Street, Post Office Box 8000
 Lompoc, CA 93438-8000
 (805) 742-3210 Fax (805)742-3263

RELEASE TO RETURN TO WORK CERTIFICATION

Employee: Please have your treating healthcare provider review your job duties with you as he/she completes this form. Return the completed form to the Certificated Human Resources Department.

Employee Name: _____ Job Title: _____

____ A. The employee is able to work a full, **regular schedule with no restrictions**, beginning _____

____ B. The employee is to **remain off work** until re-evaluated on _____

Date of next office visit _____

____ C. The employee is **able to return to work with restrictions** required by this condition beginning _____ through _____

Date of next office visit for this condition: _____

Please check and describe the restrictions required by this health condition:

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Stand (# of hrs.) _____ | <input type="checkbox"/> Concentrate | <input type="checkbox"/> Breathe |
| <input type="checkbox"/> Walk (# of hrs.) _____ | <input type="checkbox"/> Multi-task | <input type="checkbox"/> See |
| <input type="checkbox"/> Sit (# of hrs.) _____ | <input type="checkbox"/> Communicate | <input type="checkbox"/> Eat |
| <input type="checkbox"/> Lift (# of lbs.) _____ | <input type="checkbox"/> Bend, twist, stoop | <input type="checkbox"/> Think |
| <input type="checkbox"/> Push/Pull force (# of lbs.) _____ | <input type="checkbox"/> Perform manual tasks | <input type="checkbox"/> Speak |
| <input type="checkbox"/> Use of hands/fingers (repetitive motion) | <input type="checkbox"/> Reach with arms/hands | <input type="checkbox"/> Learn |

Describe restrictions, note any duties listed on the job description which are not recommended:

 Name of Treating Healthcare Provider

 Signature of Treating Healthcare Provider

 Date

 Address

 Phone