***LOMPOC UNIFIED SCHOOL DISTRICT***
*Payroll Department*
*1301 North A Street, Post Office Box 8000*
*Lompoc, CA 93438-8000*
*(805) 742-3270 Fax (805)742-3355*

# RELEASE TO RETURN TO WORK CERTIFICATION

**Employee:** When you are seeking to return to work please have your treating healthcare provider review your job duties with you as he/she completes this form. Return the completed form to the Payroll Department prior to your return to work.

**Employee Name**: ______________________________________________________________________

____ **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 _______________________________________

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

| | | |
|---|---|---|
| ☐ Stand (# of hrs.) _______________ | ☐ Concentrate | ☐ Breathe |
| ☐ Walk (# of hrs.) ________________ | ☐ Multi-task | ☐ See |
| ☐ Sit (# of hrs.) _________________ | ☐ Communicate | ☐ Eat |
| ☐ Lift (# of lbs.) _________________ | ☐ Bend, twist, stoop | ☐ Think |
| ☐ Push/Pull force (# of lbs.) _______ | ☐ Perform manual tasks | ☐ Speak |
| ☐ Use of hands/fingers (repetitive motion) | ☐ Reach with arms/hands | ☐ Learn |

Describe Restrictions:______________________________________________________________

______________________________________________________________________________

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| | | |
|---|---|---|
| **Name of Treating Healthcare Provider** | **Signature of Treating Healthcare Provider** | **Date** |
| **Address** | **Phone** | |