Medical Clearance Form

PUYALLUP SCHOOL DISTRICT
A Tradition of Excellence

EMPLOYEE INFORMATION

Employee Name: (Last, First)

Employee Title / Building

RESTRICTION INFORMATION

I certify that I have examined and determined this employee may:

☐ Return to full duty work on _____ (date) **WITHOUT** restrictions.
☐ Return to work on _____ (date) **WITH** restrictions as indicated below through _____(date)

If modified duty meeting these restrictions is not available, the employee is considered to be off work until release without restrictions.

PERMANENT RESTRICTIONS

The restrictions listed below are PERMANENT.
Employees with work restrictions seeking reasonable job accommodations under the Americans with Disabilities Amendment Act must contact the Leaves and Accommodation Coordinator and provide medical documentation of a qualifying disability.

PRESCRIBED MEDICATIONS

☐ Employee is NOT currently on any medication that would affect his/her ability to perform all work duties.
☐ Employee IS currently on medications that could affect his/her ability to perform some/all work duties.
Please list medications currently prescribed, their purpose and the time period the employee will need to take the medication.

_____ _____
Physician Signature Date

Please submit form to:
Krista McBride, HR Leaves and Accommodation Coordinator
Fax: 253-841-8650 **Email**: mcbrika@puyallupsd.org