PASADENA UNIFIED SCHOOL DISTRICT

Human Resources

MEDICAL AUTHORIZATION
and
CLEARANCE TO RETURN TO WORK

(Non-Industrial)

(Must be completed if absence lasts six consecutive days or more)

EMPLOYEE ________________________________ WORK LOCATION___________________________

JOB TITLE ____

ABSENCE FROM ___________ TO_____________ TOTAL WORK DAYS_________________________

MEDICAL AUTHORIZATION
Certification by Physician or Medical Provider

TO PHYSICIAN: Your cooperation in providing the information requested will assist the Pasadena Unified School District to authorize the employee to return to work and in providing any Sick Leave Benefits to which the employee may be entitled. Please refer to the Job Description attached, if applicable.

__________________________________ has been under my care from_______________________
(date)

to _____________________________ and was last seen by me on ___________________________
(date) (date)

I have examined the attached Job Description, and certify that the employee may return to work

without harm to himself or others as a _______________________ on_______________________
(job title) (date)

Work restrictions (If none, please state)____

____

Physician's Signature_____________________________________ Date____________________

Physician's Address ______________________________________ Phone # ________________

DISTRICT CLEARANCE TO RETURN TO WORK

_______________________________MAY RETURN TO WORK AS A ________________________

EFFECTIVE _____________________ WITH THE FOLLOWING RESTRICTIONS:_________________

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APPROVED BY: _______________________________TITLE_____________________DATE________

ORIGINAL: Employee File, Human Resources COPIES: (1) Employee (1) Supervisor