



Shoreline Public Schools  
 Office of Human Resources  
 Marie McCluskey, Leave Specialist  
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**Employee:**

- Provide this form to your Healthcare Provider for completion.
- You must have a release prior to returning.

## RETURN TO WORK RELEASE

**Employee Name:** \_\_\_\_\_

**Department/School:** \_\_\_\_\_

	Able to <b>return to a full, regular schedule</b> , with no restrictions as of _____.
	Able to <b>return to work on a reduced schedule</b> starting _____ through _____. _____ Hours per day    _____ Days per week    Comment: _____
	Able to <b>return to work with restrictions</b> starting _____ through _____. <i>Provide detailed restrictions below.</i>

**Restrictions:**

Standing (number of hours)	
Walking (number of hours)	
Sitting (number of hours)	
Lifting (maximum pounds)	
Carrying (maximum pounds)	
Use of medical equipment (crutches, cast, brace, etc)	
Other Restrictions	

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

Providers Name (Printed):

Name of Practice, Type of Practice/Medical Specialty:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_