PEARLAND INDEPENDENT SCHOOL DISTRICT
1928 N. Main Street
Pearland, TX
281-485-3203

**Date:** _____

**FAX BACK TO:** 281-412-1540
**ATTN:** Benefits Team
Human Resource Services
**PEARLAND ISD**

## DOCTOR'S RELEASE TO RETURN TO WORK FORM

Employee Name: _____

Date of Injury/illness/surgery: _____

Diagnosis or description of Injury/illness/surgery: _____

**The patient's return to work status is:**

___ Return to regular work. **No Restrictions**. Date: __/__/____

___ Able to return to work with *following restrictions. Date: __/__/____

* **Restrictions** – please list all restrictions/limitations below and the date through which they will be through:

**FOR BUS DRIVERS ONLY:**

**CAN DRIVE A BUS** _____

**NO, CANNOT DRIVE A BUS AT THIS TIME** _____

Treating Physician's Signature: _____ Date: _____

Treating Physician's Name (Print): _____

Treating Physician's Practice & Phone Number: _____