COUNTY OF SANTA CRUZ
PHYSICIAN'S CERTIFICATION FOR RETURN FROM MEDICAL/DISABILITY LEAVE

Employee Name: (print)	Employee Department:

By signing this form, I authorize the release of information necessary to process the current request for medical leave.

Employee Signature:	Date:

TO BE COMPLETED FOR THE EMPLOYEE BY THE HEALTH CARE PROVIDER

To comply with the privacy interests of employees, please do not provide information related to diagnosis (including genetic condition), treatment or other confidential medical information or records.

Please answer the below questions after reviewing the attached description of essential functions of employee's position.

1. Date that employee can **return to work** and perform essential functions of the job without endangering self or others: _____ (Date)

Ability to Perform

2. Upon return to work: If the employee is not able to perform some or all of the essential functions of their position, what functions cannot be performed?

_____

_____

_____

_____

_____

_____

_____

Light Duty Work / Work Restrictions

3. If the employee is not able to perform functions of their position, would the employee be able to perform light duty work if it is available?

☐ Yes ☐ No

If yes, what are the employee's work abilities?

_____

_____

_____

_____

_____

_____

End of Light Duty Work / Work Restrictions

4. Date that **work restrictions end** and employee can return to **full duty** work and perform essential functions of the job without endangering self or others: _____ (Date)

HEALTH CARE PROVIDER

Provider Name (print):	Provider Signature:	
Type of Practice (field of specialization):	State License #:	
Address:	Phone Number:	Date:
City/State/Zip:	FAX Number:	