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 any medical information necessary to process the current request for medical leave.

Employee Signature:	Date:

TO BE COMPLETED FOR THE EMPLOYEE BY THE HEALTH CARE PROVIDER

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

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

Ability to Perform

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

_____

_____

_____

_____

_____

_____

_____

Light Duty Work / Work Restrictions

☐ Yes ☐ No If the employee is not able to perform the functions of his/her position, would the employee be able to perform light duty work if it is available?

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

_____

_____

_____

_____

_____

_____

End of Light Duty Work / Work Restrictions

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:	