Black Gold Regional Division No.18

BLACK GOLD REGIONAL DIVISION NO. 18

Return to Work Certificate

1. Employee's Name: _____
2. Employee's Position: _____
3. Date of this return to work assessment: _____
4. Anticipated date of return to work: _____
5. Is the employee ready to return to work on a continuous basis:
   - With no restrictions? Yes ___ No ___
   - With modified work? Yes ___ No ___

   - If so, please list work-related restrictions:
     _____
     _____
     _____
6. Are the restrictions temporary? Yes ___ No ___
   - If temporary, please specify the anticipated length of the restriction(s)
     _____
     _____
     _____
   - If temporary, what is the anticipated date of the employee's next medical appointment?
     _____

Date: _____

Attending Physician: _____ (signature)
_____ (please print name)

Work Address of Physician: _____

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