ORANGE TOWNSHIP PUBLIC SCHOOL DISTRICT

Return to Work Certification Form

For Staff Members with Returning From a Leave of Absence

This form is to be completed by a certified health care provider and is intended for return to work purposes after a medical leave of absence due. An employee who has taken such a medical leave must present this form to Human Resources prior to returning to work.

For Health Care Professionals:

All healthcare providers must adhere to the current CDC guidelines regarding an employee's safe return to work, keeping in mind that the patient works in a large public-school district.

This patient has three return-to-work options:

- Full Release. The patient has no work restrictions. They can return to their prior position because you, the health care provider, certify that they can perform the essential functions of their job as per CDC guidelines.

- Modified Duty. The patient has some work restrictions. Work restrictions must be specifically notated in the specified area on this form. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job as per CDC guidelines and return to work.

- Not Released. The patient is not released to work in any capacity as per CDC guidelines and due to medical related limitations.

Submission the Return to Work certification (see next page) must be submitted to:

Sanaa Hayden
Confidential Secretary of Human Resources
Orange Township Public School District
451 Lincoln Avenue
Orange, NJ 07050
Email: haydensa@orange.k12.nj.us
Telephone (973) 677-4020

For Staff Members Returning From a Leave of Absence
(To be completed by the staff member's treating physician)

Employee/Patient Name (Last, First, & Middle): _____

Date of Exam:

Employee's Release of Duty Status:

□ Full, unrestricted duty effective _____/_____/_____

□ Modified duty effective ____/_____/_____ and next evaluation date _____/_____/_____

□ Not released for any type of duty. Next evaluation date will be _____/_____/_____

Return to Work Practices and Work Restrictions

I hereby certify that the facts in this document are true and correct.

Health Care Provider (Name of Practice):

_____

Name (print): _____

Signature: _____

Phone Number: _____

Date: _____