

Santa Monica-Malibu Unified School District

1651 Sixteenth Street § Santa Monica, CA 90404-3891 § 310/450-8338 § Ext. 310
Fax (310) 452-34 68

CERTIFICATE FOR RETURN TO WORK OR FURTHER TREATMENT

Name of Employee _____ Job Title _____ Date _____
Industrial Injury Yes No

Diagnosis _____

The above employee has been under my care from _____ (Date)

He/she may return to full work duties on _____ (Date) Follow up visit (if needed) _____ (Date)

He/she may return to work modified to accommodate the following restrictions on _____ (Date), but has another office appointment on _____ (Date) at _____ (Time).

Patient is restricted from:

- | | | | |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Bending at waist | <input type="checkbox"/> Use of Ladder | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Reaching overhead | <input type="checkbox"/> Prolonged Sitting* | <input type="checkbox"/> Work at Heights | <input type="checkbox"/> Other* |
| <input type="checkbox"/> Prolonged Standing* | <input type="checkbox"/> Lifting _____ (Limit) | (* Doctor's statement req.) | |

He/she may not return to work before this office has seen him/her on _____ (Date) at _____ (Time)

Doctor's Statement _____

Doctor's Signature License Number Expiration Date

PLEASE PRINT:

Doctor's Name _____

Address _____

Phone _____

Modified work assignment offered by District on _____ (Date).

Employee Accepts Offer

Employee Rejects Offer

Employee Signature Date

Status - Restrictions: Yes No

Approved: Yes No

Supervisor:

Signature Date

Human Resources:

Signature Date

Return original and all copies to your Supervisor. Supervisor to forward copies to Human Resources, Risk Management and Payroll. (This form requires renewal every 30 days.)