EMPLOYEE RETURN TO WORK
MEDICAL HISTORY AFFIDAVIT

A. To be completed by employee:

Employee Name (Printed)

Position Title

Department and Location

1. Do you have any circumstances that would limit your ability to perform the essential functions or meet the physical requirements of your position: _____No _____Yes

   If yes, explain:

Employee Signature

Date

B. Must be completed by Physician or Health Care Practitioner BEFORE returning to work:

1. Dates this employee was under my care and supervision for medical condition(s):

Is employee able to return to work and perform the essential functions of employee's position to include the physical requirements? (Answer after reviewing the job description of essential function of employee's position, or, if a job description is not proved, after discussing with employee.) _____Yes _____No

If no, explain:

EMPLOYEE RETURN TO WORK
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If restrictions are necessary, please explain:

_____

_____

_____

_____

_____

Date released to return to work: _____

_____
Physician or Health Care Practitioner (Printed)

_____ _____
Physician or Health Care Practitioner (Signature) Date

Received and reviewed by LCC Human Resources Department:

_____ _____
Human Resources Director or
Human Resources Designee Date