RELEASE TO RETURN TO WORK

***COMPLETED FORMS CAN BE RETURNED IN-PERSON, EMAILED TO : ERSTAFF@SLPS.ORG OR**

VIA FAX (314) 244-1739*

Your "**Release to Return to work**" document must be submitted to the Human Resources Division, if at all possible, at least two weeks (14 days) prior to the indicated return date.

PLEASE PRINT:

Today's Date: _____ Employee Number: _____

Employee Name: _____ Location/Position: _____

Leave Start Date: _____ Date of Return to Work: _____

Employee Signature _____

Date _____

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IF RETURNING FROM FMLA OR OTHER LEAVE THAT IS MEDICALLY RELATED

To be completed by the Health Care Provider:

I hereby certify that (patient's name) _____ was under my professional care for (nature of injury or illness)_____

_____

For the period beginning _____and ending _____.

I further certify that he/she is free from any communicable disease and that he/she is physically and mentally capable of performing his/her full duties as a teacher/employee, effective _____.

Name of Health Care Provider (Print):_____

Signature of Health Care Provider _____ **Mailing Address** _____

_____

Type of Practice (Field of Specialization, if any) _____ _____

Date _____