Certification of Health Care Provider/Employee Return to Work Release

Employee Name: _____

Date of this Certification:_____

Company/Employer Name_____

To Whom It May Concern:

I hereby certify that the employee named above may return to his/her position of _____[insert position] on _____[insert date]. The employee is able to perform the essential functions of the identified position. I am familiar with the essential job duties of the employee's position based on (1) a review of a job description provided to me, (2) a discussion with the employee of the position's essential functions, or (3) [**Describe how essential job duties of position were determined**] _____
_____
_____
_____

_____ _____
Signature of Health Care Provider Date

Health Care Provider Information:

_____
Name

_____
Address

_____ _____ _____
City State Zip

_____
Telephone

Please return this Certification to:

_____
Representative

_____
Company Name

_____
Address

_____ _____ _____
City State Zip

_____ _____
Phone No. Fax No.