

**CAMERON PARISH SCHOOL BOARD**  
**Charles Adkins, Superintendent**  
**510 Marshall St.**  
**Cameron, LA 70631**  
**Phone: 337-775-5784 Fax: 337-775-5572**  
**www.camsch.org**

## MEDICAL RELEASE TO RETURN TO WORK

### To be completed by employee:

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

School/Department: \_\_\_\_\_

### To be completed by physician:

*This is to verify that the above named patient, under my care, will be medically able to*

*Return to work on:* \_\_\_\_\_

*Additional Comment:* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Physician's Name and Address:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Physician's Signature:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### To be completed by School Principal (School Employees) or Supervisor (Central Office Employees):

*This is to verify that the above individual returned to full time work on:*

\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Principal or Supervisor submit the original of this form to the Payroll Department no later than (2) days following the employee's return to work.*

Submit original form to Superintendent