Return to Work Medical Certification

Lakeland School District

PART I: TO BE COMPLETED BY EMPLOYEE

1. Name of employee _____

2. Employee's Position _____

3. Date leave commenced _____

4. Date Employee can return to Work _____

5. Signature of employee _____ _____ Date

PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

6. I certify that on _____ (Date), _____ (Name of Employee)

is able to resume performing the functions of his/her position with or without reasonable accommodation.

_____ Physician Signature _____ Date

7. Health care provider's name, address & telephone number.

This form should be delivered or mailed to:

Lakeland School District
R. Scott Jeffery, Superintendent
1355 Lakeland Drive,
Scott Township, PA 18433