File: GCBE-F-6

PHYSICIAN'S CERTIFICATION OF EMPLOYEE'S RETURN TO WORK

**** To be completed and returned at the time the employee is able to return to work****

1. Employee's Name: _____

2. Employee's ID# _____

3. Employee Phone Number: _____

4. School/Department: _____

5. Position: _____

I have examined my patient, _____, and can certify that he/she will be physically able to resume his/her contractual responsibilities at the beginningu of the workday on _____.
(month, day, year)

_____ _____
Signature of Physician Date

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

_____
Business Name Address Phone

_____
City State Zip

Please return completed form to:

Portsmouth Public Schools
Department of Human Resources
801 Crawford Street 3rd Floor
Portsmouth, VA 23704
(757)393-8751
Fax: (757)393-5238