YUBA COUNTY PHYSICIAN'S RELEASE
RETURN TO WORK FORM "WITH" or "WITHOUT" RESTRICTIONS

Employee Name: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The above employee is hereby **released to restricted duty** on _____ (Date), as s/he is able to perform the essential job functions as recorded on the accompanying "Class Specification" *with restrictions* as described below. (ex. unable to lift more than 15 lbs, alternate sit/stand, no stooping/bending, may not rotate torso beyond 40 degrees, can only work 4 hours a day, etc.)

Restriction(s):

_____

_____

_____

_____

_____

Next appointment or evaluation date: _____

The above employee is subsequently **released to full duty, on** _____ (Date), as s/he is able to perform the essential job functions as recorded on the accompanying "Class Specification" *without restrictions*.

_____ _____

Health Care Provider (Please Print Name) Type of Practice

_____ _____

Address Telephone Number

_____

City, State, Zip Code

_____ _____

Signature of Health Care Provider Date