

Certification of Physician or Practitioner for Employee to Return to Work

Employee Name: Tad Paddock

Date Employee May Return to Work: _____ for the job title: Restaurant General Manager

Please check one of the following options to indicate his/her ability to perform the essential functions of their job.

Full Duty

I hereby certify that the employee named above may return to work on the above date. The employee is able to perform the essential functions of the position. My opinion is based on a discussion with the employee of the position's essential functions.

Modified Duty

I hereby certify that the employee named above may return to work on the above date. However, the employee needs the following proposed accommodations in order to perform the essential functions of the position. My opinion is based on a discussion with the employee of the position's essential functions.

Proposed accommodations:

Signature of Physician or Practitioner

Date

Physician or Practitioner Information:

Name

Address

City

State

Zip

Phone

Upon returning to work, this form must be returned to:

Carol Bell

Sierra Bell's, Inc.

2764 Compass Drive, Ste. 101

Grand Junction, CO 81506