RETURN TO WORK CERTIFICATE FOR TEACHERS
PALLISER REGIONAL SCHOOLS NO. 26

APPENDIX 2

1 Teacher's Name: _____

2 Job Title/Occupation: _____

3 Date of this return to work assessment: _____

4 Anticipated return to work date: _____

5 Is the teacher ready to return to work:

a. With NO restrictions? Yes ___ No ___

b. With MODIFIED duties? Yes ___ No ___

c. If so, please list the work-related restrictions:

_____

_____

_____

6 Are the restrictions temporary: Yes ___ No ___

a. If temporary, please specify the anticipated length of the restriction(s) using days, weeks or months: _____

b. If temporary, what is the anticipated date of the teacher's next medical appointment:

_____

Date of Form Completion: _____

Attending Physician: _____ (Physician's signature)

_____ (Physician's printed name)

Work Address of Attending Physician: _____