

Mid-Ohio Psychological Services, Inc.
Return to Work Medical Certification

Upon return from your medical leave, you must obtain and have *your attending* health care provider complete this *Return to Work Medical Certification* form. You ***WILL NOT*** be permitted to resume work until it is provided.

To be completed by the Employee.

Employee's Name: _____ SSN: _____

Employee's Position: _____

Date leave commenced: _____

Date of planned return to work: _____

Employee's Signature: _____ Date: _____

To be completed by the Health Care Provider.

I certify that _____ is able to resume performing the functions of his/her position effective _____.

Provider's Signature: _____ Date: _____

Health Care Provider's Name: _____

Address: _____

Telephone Number: _____

Employer Remarks:

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