Employee Reinstatement /
Return to Work Form

Employee Reinstatement/Return to Work Form

This form must be completed by the treating physician.

____, ___________________, has my permission to
(Employee Name) *(DOB)*

return to work on _________________________. They have been under my care for the following:
(Date)

They are subject to the following work limitations/restrictions (**This line must be completed**. If there are no limitations/restrictions, it must be indicated below as "NO RESTRICTIONS OR LIMITATIONS."):

These work limitations/restrictions should be in effect until ________________________________.
(Date)

Comments

If this form has been completed by one of the following, the supervising/collaborating physician must sign here to verify the accuracy of the information on this form: medical doctor-in-training (MT), certified nurse midwife (CNM), physician's assistant (PA-C), doctor, nurse practitioner (DNP), and certified registered nurse practitioner (CRNP).

Health Care Provider

Print Name:______________________________Signature:_________________________Date:_________

Address:____

Phone: ___________________________ Fax: _____________________________

Health Care Provider

Print Name:______________________________Signature:_________________________Date:_________

Address:____

Phone: ___________________________ Fax: _____________________________

Return this form to School District of Pittsburgh, 341 S. Bellefield Avenue, Room 139, Pittsburgh, PA 15213 or fax this form to (412) 622-7981.

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 Updated 10/01/15