Little Rock School District
HUMAN RESOURCES DEPARTMENT
RETURN TO WORK CERTIFICATION
Medical Leave

HEALTH CARE PROVIDER

Employee Name: *(Print)* _____ Job Title: _____

Health Care Provider's name: *(Print)*_____

Health Care Provider's business address: _____

Name of business_____ Type of practice/Medical specialty: _____

Telephone: _____Fax: _____ Email: _____

Employee is released to return to work effective: _____ *(mm/dd/yyyy)*

Based on the above employee's job title, the employee is able to perform the essential functions of the position?

— Without restrictions or accommodations

— With restrictions or accommodations

Please list any restrictions/limitations or describe accommodations which LRSD should consider:
_____
_____
_____

Are the restrictions/limitations:
— Permanent
— Temporary, until: _____ *(mm/dd/yyyy)*

Comments:
_____
_____
_____
_____

Signature of
Health Care Provider: _____ Date: _____*(mm/dd/yyyy)*

Please return this form to the employee or send it to:

LRSD Human Resources Medical Leave
810 W. Markham
Little Rock, Arkansas 72201
Office: 501-447-1100
Fax: 501-447-1162