

**City of Hot Springs
Return to Work Certification**

Employee:

Employee's Department:

City of Hot Springs Address:

Human Resources Contact:

Telephone Number:

Fax Number:

HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE DEPARTMENT LISTED ABOVE

Please review the attached job description. Is the employee able to perform all the functions of his or her job?

- Yes
- No
- Yes, with restrictions

Please list any restrictions or functional limitations which the department should consider.

Are the restrictions:

- Permanent
- Temporary, until (date):

Please address this employee's long term prognosis in terms of their current condition and express any additional comments.

Employee is released to return to work effective (date):

Name of Health Care Provider:

Specialty:

Address of Health Care Provider

Signature of Health Care Provider

Date