SOUTHERN WEST VIRGINIA COMMUNITY AND TECHNICAL COLLEGE

Number: SCP-2484.C
Effective: September 01, 2000

RETURN TO WORK AUTHORIZATION MEDICAL RELEASE FORM

PHYSICIAN - COMPLETE IN ENTIRETY:

Patient's Name: _____

Social Security Number: _____

I hereby certify that the above-named employee has been under my professional care for:

_____
(Diagnosis)

Illness commenced: _____
(Date)

Employee is able to return to work on: _____
(Date)

Describe the functional limitations/restrictions, if any, caused by this condition:

_____

_____
(Functional limitations listed may require an analysis of employee's Position Information Questionnaire (PIQ) for ADA accommodation)

Duration of limitations/restrictions, if any: ❒ Permanent ❒ Temporary

If temporary, indicate time period: _____

_____
Signature of Physician

_____
Printed Name

_____
Address of Physician

_____
Telephone Number of Physician