APPENDIX – C

Supervisor's Statement of Employee's Return to Work

I certify that _____ **returned to work on** _____**.**
Employee's Name Date

_____ _____
Supervisor's Signature Date

Send this signed form to the Human Resources Department promptly, along with the physician's note returning the employee to work (along with or without restrictions), and the completed Physical Capabilities form if applicable.

Please check the statement which applies:

Employee Returned to Full Duty with No lost time or Without Light Duty Restrictions _____

Employee Returned to Work with Light Duty Restrictions _____

Restrictions: _____

_____

Restrictions effective through (date): _____