**Certification of Health Care Provider for Employee Return to Work (OV3003)**

Employee's Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Employee May Return to Work: \_\_\_\_\_\_\_\_\_\_

I have reviewed the Job Description and the Job Description Supplement with the employee. It is my opinion that the employee may return to work as follows:

**□ COVID-19 Symptom and Virus**

To the best of my knowledge the employee is both symptom and COVID-19 virus free and does not pose a risk of eminent harm to self or others.

**□ Full Duty**

The employee is able to perform the functions of the job position without any job modifications or accommodations.

**□ Modified Duty**

The employee is able to return to the job position with the restrictions listed below. **[If the employee is in need of light duties, please be very specific regarding what function(s) the employee is able to perform. Ie. the amount of weight that can lift, duration for standing, walking, carrying, etc. The term “light duty” is not specific enough.]**

**Proposed accommodations and/or identified restrictions:**

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**Duration of the aforementioned accommodations and/or identified restrictions:**

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**Health Care Provider Information:** Telephone (\_\_\_) \_\_\_-\_\_\_\_ Fax (\_\_\_) \_\_\_-\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name Address City State Zip

**Signature of Health Care Provider**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF THE YOU ARE UNABLE TO SECURE A MEDICAL APPOINTMENT TO OBTAIN**

**RETURN TO WORK (RTW) RELEASE PLEASE COMPLETE THE FOLLOWING. Check all that apply:**

**** I have attempted to schedule an in person medical appointment to secure a signed RTW release unsuccessfully.

**** I have attempted to schedule an internet medical appointment to secure a signed RTW release unsuccessfully.

** I am self-confirming that at this time I am completely symptom free from COVID-19:**

Symptoms Include: Cough, fever, tiredness, difficulty breathing (severe cases)

**Signature of Health Care Provider**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form must be returned to:**

COMPANY REPRESENTATIVE, PHONE, EMAIL, ADDRESS