Jenks
Public Schools

NOTICE OF INTENT TO RETURN TO WORK

Name: _____

Principal or Supervisor: _____

Date leave began: _____ Date leave will end: _____

I understand that as a condition of my return to work, I must provide written certification from my health care provider that I am able to resume working and can perform, with or without reasonable accommodations, the essential functions of my position.

_____ _____
Date Employee's Signature

STATEMENT OF HEALTH CARE PROVIDER

I have examined _____and can certify that

he/she is fully able to resume work on _____(date).

Restrictions: ❒ Yes ❒ No

If yes, please describe restrictions: _____

_____

_____

_____

_____ _____
Date Health Care Provider Signature

_____
Printed Name of Health Care Provider

This form must be presented to Human Resources five (5) days prior to returning to work.
Fax (918) 298-6602 Phone (918) 299-4415 Ext. 2306