

Oregon Military Department
RELEASE TO RETURN TO WORK
Federal and Oregon Family and Medical Leave Acts

TO BE COMPLETED BY EMPLOYEE

Employee's Name _____

Employee's Social Security # _____ Section: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN OR PRACTITIONER

1. The above named individual was examined on _____

2. Period of Disability: I certify that from _____ to _____ the above named individual was (a) unable to perform the physical requirements of his/her work and (b) medically disabled.

Totally _____ *Partially _____

*IF PATIENT IS PARTIALLY DISABLED, COMPLETE THE FOLLOWING:

Number of hours per day patient is able to work _____

Number of days per week patient is able to work _____

Limitation: Bending _____ Lifting _____ Walking _____
 Sitting _____ Standing _____ Other _____ **

** Please explain _____

3. Date patient is able to return to work full time with **NO** limitations _____

Additional comments _____

Physician's/Practitioner's Name (please print)

Physician's/Practitioner's Signature

Physician's/Practitioner's Address

Date

PRIOR TO RETURNING TO WORK, A COPY OF THIS FORM MUST BE SUBMITTED TO THE EMPLOYEE'S MANAGER/SUPERVISOR AND THE ORIGINAL SENT TO:

Oregon Military Department
Attn: State Personnel Office – AGP
PO Box 14350
Salem, OR 97309-5047
Fax (503) 584-3556