Department of Administration
HUMAN RESOURCES & RISK MANAGEMENT DIVISION
107 Municipal Way, Room 101
Phone: (907)586-5250 Fax: (907)586-5392

Return to Work Certification Medical Leave

Section A: Employee Information (to be completed by employee)	
Last Name:	Department contact:
First Name:	Phone #:

I am required to maintain a Commercial Driver's License to perform the essential functions of my position.
☐ Yes ☐ No

Pursuant to federal law, the City's Drug and Alcohol Testing Administrative Policy 19-02R states:

No covered employee shall report to duty or remain on duty requiring the performance of safety-sensitive functions when the covered employee has used any drug that may adversely affect the covered employee's ability to perform safety-sensitive functions, unless its use is pursuant to the instructions of a licensed medical practitioner who advised the covered employee that the drug does not adversely affect the covered employee's ability to safely perform safety-sensitive functions.

Section B: Health Care Provider (to be completed by Health Care Provider)

Please complete the following and return **to the department prior** to the return to work date.

If employee indicated above that they are required to maintain a commercial driver's license to perform the essential functions of their position, please indicate below whether or not any medication they are taking would adversely affect their ability to safely operate a commercial motor vehicle.

Section C: Please review the attached job description and complete this section for return to duty.

The above name employee is under my care. I release him/her to return to work as specified below:

☐ Fully duty, usual job, no restrictions as of: (date)

☐ Light duty release as of (date) with the following work restrictions and duration:

☐ The employee is not able to perform work of any kind. (date)

Are the restrictions: ☐ Permanent ☐ Temporary, until (date):

Comments:

Name of Health Care Provider:

Specialty:

Address:

Phone number:

My signature below verifies that the information provided above is true and accurate.

Health Care Provider Signature _____ Date _____

Health Care Provide Printed Name _____

Return Completed Form to Department