

CITY OF CANTON
RETURN TO WORK FORM

PLEASE FACSIMILE FORM
TO 330/489-3368

THIS FORM MUST BE SUBMITTED TO HUMAN RESOURCES FOR APPROVAL PRIOR TO THE DATE YOU EXPECT TO RETURN TO WORK.

EMPLOYEE NAME _____ DATE _____

DEPARTMENT _____

REASON FOR ABSENCE _____

DATE LAST WORKED _____

Medical Condition Treated _____

Date Released by Physician _____

Is this employee capable of performing ALL work of his/her current position? NO _____
YES _____

Can this employee perform in his current position without risk of injury to himself, fellow employees or citizens of the City of Canton given his present medical condition?
_____ YES _____ NO

If not, what restrictions and limitations exist? _____

Comments _____

Date

Signature of Physician

Authorized to Return to Work: _____ NO _____ YES DATE: _____

Human Resources

Date

Original: Human Resources
Copy Department Head
Employee