PITT COUNTY SCHOOLS

Return to Work

To Be Completed By Employee: Employee ID Number:

Name:	School/Position:
SSN:	Phone Number:

Complete this form when returning to work from a leave of absence (medical, maternal, educational, disability, etc.) Submit this form to your supervisor **PRIOR** to beginning work. Failure to do so will not guarantee accurate reinstatement records for personnel, payroll and benefits.

Type of Request:
- ☐ New
- ☐ Revision

Return to Work Date:

_____

- ☐ Full Duty
- ☐ Light Duty

Note: Physicians need to complete this section when returning from a medical leave of absence.

I certify that _____ is able to return

to work to perform his/her regular job _____
. Effective Date

_____ _____
Physicians Signature: Date:

Address:

_____

Telephone: _____

Restrictions:

Central Office Use:

___ HR ___Payroll

___Benefits

___ School ___ Employee

_____ _____
Employee Signature: Date:

_____ _____
Supervisor Signature: Date: