Medical Release to Work

Part I: To be Completed by Employee
(Please print)

1. _____
   First Name Middle Initial Last Name

2. _____
   Position/Title

3. _____
   Date leave commenced

4. _____
   Signature Date

Part II: To be completed by Employee's Health Care Provider

5. I certify that on_____ the named employee is able to resume performing the functions of his/her position with or without reasonable accommodation. Necessary accommodation(s) is/are as follow(s):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of Health Care Provider Date

This form is to be given to the Manager and sent to HR. Once employee is cleared by Premiere Dental you will be given your return-to-work date and be authorized to report to your manager for your scheduled shift.