

**CLACKAMAS COUNTY**  
**RELEASE TO RETURN TO WORK**

**Please Type or Print**

**PART 1: TO BE COMPLETED BY EMPLOYEE**

Employee's Name \_\_\_\_\_

Employee's ID No \_\_\_\_\_

**PART 2: 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 \_\_\_\_\_

Limitations

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**

Employee's Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Prior to returning to work, a copy of this form must be submitted to the employee's supervisor  
and the original sent to:**

**Clackamas County Risk/Benefits Division  
Public Services Building  
2051 Kaen Rd., 3rd Floor  
Oregon City, OR 97045**