CITY OF SLIDELL

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Department of Human Resources

Name: _____ Department: _____

Signature: _____ Date: _____

You have been absent from your job for three (3) consecutive working days or more due to illness or injury, or have had an "out-patient" procedure performed or had an overnight stay or "in-patient" care in an institutional facility. Therefore, **before** returning to work, the City requires that you follow the necessary steps listed below:

1. You are to have the **RETURN TO WORK APPROVAL**, provided on this form completed by the physician who is in charge of your care for your medical condition.
2. You are to bring this completed form to the ***Human Resources Office***, at which time an authorized individual on the Human Resources staff will contact your department to obtain the date and time that you may report for duty.

John Welborn, Chief of Staff — Date Signed: 3/20/19

RETURN TO WORK APPROVAL

I, _____ (Type or Print Physician Name), approve for _____ (Type or Print Employee Name)

an unconditional return to full duties to the position of _____ (Position Title)

effective _____ (Release to full duty date).

A copy of the employee's job description has been provided to my office for review.

If any residual disability exists concurrent with an unconditional release to return to full duty, I have stated the percent of disability and have attached a complete explanation of the nature of the employee's disability.

Signature of Physician — Date Signed

FOR HUMAN RESOURCES STAFF USE ONLY

Date Received: _____ Return to Duty Date: _____

Human Resources Department Representative Signature — Person Contacted