



# CITY OF SLIDELL

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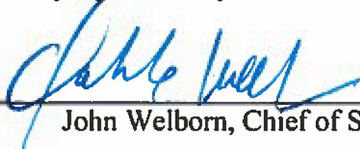
Department of Human Resources

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

3/20/15  
\_\_\_\_\_  
Date Signed

.....  
**RETURN TO WORK APPROVAL**

I, \_\_\_\_\_, approve for \_\_\_\_\_  
(Type or Print Physician Name) (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