

Cohoes City School District
Administration Center
Personnel Office
7 Bevan Street
Cohoes, New York 12047

Phone: (518) 237-0100

Telefax: (518) 237-2912

RETURN-TO-WORK AUTHORIZATION FORM		
(To be completed by employee)		
Employee Name:		
Department:		
Dates out of work:	From:	To:
(To be completed by treating physician)		
Date of last evaluation:		
Date of next evaluation:		
I have reviewed the employee's job description and the employee may return to:		
<input type="checkbox"/> Regular duty as of: _____ without restrictions or limitations.		
<input type="checkbox"/> Modified duty as of: _____ with the following restrictions.		
And/or the following accommodations:		
Physicians name (please print):		
Physician Signature:		
Address:		
Phone number:		