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:

☐ Regular duty as of: _____ without restrictions or limitations.

☐ Modified duty as of: _____ with the following restrictions.

And/or the following accommodations:

Physicians name (please print):

Physician Signature:

Address:

Phone number: