



SAN ANTONIO INDEPENDENT SCHOOL DISTRICT
REQUEST TO RETURN TO WORK FORM

I hereby request that my health/disability leave be terminated and that I be returned to active duty status. To the best of my knowledge, I am physically and mentally capable of carrying out my job responsibilities.

EMPLOYEE'S SIGNATURE

DATE

Employees currently on leave and who are ready to return to work must complete this form and return it to the Employee Benefits, Risk Management, and Safety department prior to returning to his or her assigned campus or department. If the employee returns to work without a clearance from the Employee Benefits, Risk Management, and Safety department the employee shall be subject to disciplinary action.

TO BE COMPLETED BY THE PHYSICIAN WHEN THE EMPLOYEE IS FULLY ABLE TO RETURN TO WORK

1. Any remaining symptoms: _____

2. Continued treatment: _____

3. Prognosis: _____

4. My patient and I are fully aware of the essential functions associated with the position and the physical and mental demands of his or her job responsibilities. In my professional opinion _____ is fully recovered and will be able to assume all the responsibilities of his or her job on _____.
(date)

PHYSICIAN'S PRINTED NAME

PHYSICIAN SIGNATURE

DATE

San Antonio Independent School District does not discriminate on the basis of race, religion, color, national origin, gender, or disability in providing education services, activities, and programs, including vocational programs, in accordance with Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Educational Amendments of 1972; Section 504 of the Rehabilitation Act of 1973, as amended.