CERTIFICATE OF MEDICAL RELEASE

Please return completed form 10 days prior to your anticipated return to work date.
Forms can be submitted to Absence Management using one of the following methods:
Mailed to Prince George's County Public Schools, ATTN: Absence Management, 14201 School Lane, Room 132, Upper Marlboro, MD 20772. Scanned or E-mailed to: absence.mgmt@pgcps.org

SECTION I: TO BE COMPLETED BY THE EMPLOYEE PRIOR TO GIVING TO YOUR HEALTHCARE PROVIDER.

Employee's Name_____ EIN:_____

Work Title: _____ Work Organization:_____

Phone #:_____ Personal Email address:_____

This is an acknowledgment that this Certificate of Medical Release Form is for employees who can never retrun to work, who can return to work in a full duty capacity (no restrictions); or who can return to work with temporary restrictions. This form can not be used if the employee has or needs reasonable accommodations. Accommodations must be submitted using the Administrative Procedure 4172 - Requests For Reasonable Accommodation process and must be approved by the Equity Assurance Office. Submissions of accommodation request does no prohibit an employee from returning to work after the expiration of the medical leave and/or based on the recommendation of their physician.

Any employee submitting this form will receive a Return to Work Letter from Absence Management and will be required to return to work (unless deemed not to return to work) on the date and to the location. An employee who does not to return to work on the designated date and/or location will be charged unpaid leave and will be refered to ELRO for disciplinary action.

Please be advised, you can not return to work prior to receiving an Official Return to Work Letter from Absence Management.

Employee's Signature: _____ Date: _____

Employee Assistance Program: To demonstrate its commitment to reducing employee stress, turnover and health care costs, PGCPS provides an Employee Assistance Program (EAP) for all full-time employees. EAP is a confidential and professional consulting service that is available 24 hours a day and 7 days a week. If you are in need of EAP services, they can be reached at 1-800-346-0110 or via the web at Inova Employee Assistance Program Username: PGCPS Password: PRINCE

SECTION II: TO BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER ONLY. Select one option only.

☐ Employee can never return to work, please indicate one of the following and provide supporting documentation for either selection:

- ○ Employee can never return to the current position
- ○ Employee can never work in any capacity

☐ Employee is medically released to return to work:

- ○ Return to full duty without restriction. Date of Return_____
- ○ Return to duty with Temporary Restrictions not to exceed 90 calendar days. Employee must be able to return to full duty on day 91. Use actual dates below (do not enter TBD, Unknown, etc):

  Beginning date:_____ Ending Date:_____

Identify the termpoary restrictions the employee is unable to perform:

☐ Sitting long periods of time ☐ Standing long periods of time ☐ Driving ☐ Lifting more than ____lbs

Temporary Restrictions are limited to a maximum of *90 calendar days* and cannot be extended.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Health Care Provider's Name: _____Provider's ID #_____
Business Address:_____
Phone # (Required): _____ Practice Specialty: _____

Signature of Health Care Provider *(Do not use a stamp)*:_____ Date:_____

Revised 9.29.23