Anne Arundel County Public Schools | Division of Human Resources

Physician Return to Work Authorization – Mental/Emotional/Cognitive Health

Directions: *To be completed by the employee's health care provider in anticipation of employees return to work from medical leave.*
Submit to: *AACPS Office of Integrated Disability & Leave Management, 2644 Riva Road, Annapolis, MD 21401;* ***e-fax: 443-458-0140.***

Employee Name	Date of Birth	Job Title

Doctor's Name	Next Scheduled Appointment

☐ The patient may return to work ***without any limitations*** on _____ (Date)

☐ The patient may return to work ***with limitations*** on _____ (Date)

☐ The patient can return to work ***Part-time*** _____ hours/week for _____ (duration)

If there are any limitations, ALL boxes below must be filled out.

The patient is able to:

		No Limitations	Some Limitation	Significant Limitations
1	***Understand*** directives and procedures.	☐	☐	☐
2	***Remember*** directives and procedures.	☐	☐	☐
3	***Concentrate*** on tasks for extended periods.	☐	☐	☐
4	***Sustain*** ordinary routine without special supervision (persist at tasks).	☐	☐	☐
5	Perform activities ***within a schedule***.	☐	☐	☐
6	***Maintain attendance***, and be punctual within customary tolerances.	☐	☐	☐
7	***Make decisions***.	☐	☐	☐
8	***Interact appropriately*** with general public, co-workers, and students (where applicable).	☐	☐	☐
9	Accept instructions and ***respond appropriately*** to criticism from supervisors.	☐	☐	☐
10	Adhere to basic standards of neatness and cleanliness.	☐	☐	☐
11	***Respond appropriately to changes*** in the work setting, e.g., learn new skills and/or tasks, deviate from routine procedures, adapt to changes in the the work environment, etc.	☐	☐	☐
12	Be aware of normal workplace hazards and ***take appropriate precautions***.	☐	☐	☐
13	Travel between work locations (where applicable).	☐	☐	☐

Please explain further any of the limitations marked above.	Are these limitations: ☐ Temporary ☐ Permanent *If temporary, for how long?*	Specify any environmental requirements or assistive devices, if applicable

Signature of Doctor *Date* *Phone Number*

Address *Fax Number*