

**WHITMAN COUNTY  
400 N. MAIN STREET  
COLFAX, WASHINGTON 99111**

**RELEASE TO RETURN TO WORK  
REGULAR DUTY**

Employee's Name (Print): \_\_\_\_\_

Employee's Department: \_\_\_\_\_

This is to certify that the above-named patient was under my professional care from \_\_\_\_\_  
to \_\_\_\_\_, inclusive, and was totally incapacitated during that time.

This is to further certify that the above-named patient has now recovered sufficiently to be able to return to  
**regular work duties** on \_\_\_\_\_.

Work duties and activities shall include the following:

*See attached position description*

\_\_\_\_\_  
Doctor's Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee's Supervisor Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

Date: \_\_\_\_\_