

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

**RELEASE TO RETURN TO WORK
LIGHT 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
light work duties on _____.

Work duties and activities shall be restricted to the following:

[INSERT THE POSITION'S ESSENTIAL FUNCTIONS AND PHYSICAL REQUIREMENTS]

Please list any lifting or motion restriction: _____

Doctor's Signature

Date

Employee's Supervisor Signature

Date

Employee's Signature

Date