World Wide Technology, Inc.

Return to Work Certification Form

You and your Health Care Provider must complete this form. You are required to submit the completed form to HR prior to returning or upon returning to work. This can be provided in-person, email, or faxed to HR (Fax: 314-919-1441).

Employee Name: (Please Print) _____

Date Leave Started: _____

I understand that I cannot return to work without a release from my health care provider.

_____
Employee Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER **(Please Print or Type)**

Please select:

☐ Employee is released to regular duty with NO restrictions**.** Date released:_____

☐ Employee is released to duty with restrictions (please specify below). Date released: _____

Nature of the accommodation: (Please be specific)

_____
_____
_____

Nature of limitation: (Please be specific)

_____
_____
_____

Please list any other restrictions or comments:

_____
_____
_____

Estimated duration of restrictions:

_____

Health Care Provider Name: (Please Print) _____

_____
Health Care Provider Signature Date