CERTIFICATE OF MEDICAL RELEASE

Please return completed form to: Prince George's County Public Schools,
ATTN: Absence Management, 14201 School Lane, Room 132. Upper Marlboro, MD 20772.
Phone: 301-952-6200 FAX: 301-760-3593. E-mail: absence .mgmt@pgcps.org

[redacted]

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

Employee's Name_____ EIN:_____
First Middle Last

Work Title: _____ Work Organization:_____

Employee's Signature: _____ Home Phone #:_____

SECTION II: TO BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER ONLY.

1) Date employee may return to work:_____

2) The patient is medically released: **(Please select only one)**

- ☐ Never return to work
- ☐ Return to full duty without restriction (**Certificate of Medical Release is REQUIRED 10 days prior to your return**.)
- ☐ Return to duty with Temporary Restrictions: Beginning date:_____ Ending Date:_____

Temporary Restrictions are limited to ***90 calendar days*** and cannot be extended. See Temporary Restriction Placement information on Absence Management portion of the PGCPS website: https://www.pgcps.org/payroll/absence-management/

****If medical restrictions are specified, your documentation will be reviewed for Temporary Restriction Placement. You will *NOT* be authorized to return back to work until you have received notification that your Temporary Restrictions will be met.****

Identify the functions employee is unable to perform:

____Sitting long periods of time ____Standing long periods of time

____Driving ____Working less than 8 hours in a day ____Lifting more than ____lbs

Other Temporary Restrictions: _____

_____

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:_____

Telephone: ( ) _____ Fax: ( ) _____Practice Specialty: _____ *(Required)*

Signature of Health Care Provider:_____ *(No Stamp)* **Date:_____**