Return to Work Certificate

Date: ________________________

To Whom It May Concern:

_____________________________________ has been under my care since _________________________.

He/She is able to return to work on/in ___________________________________.

_________ No Restrictions

_________Restrictions _________ Light Duty for _______ days (s) _________ weeks.

Please List Restrictions Here:

____

Health Care Provider Signature

____

Phone Number

*Your doctor may use his/her own return to work form. Form must be sent to:

Texas A&M University-Corpus Christi

6300 Ocean Drive, Unit 5730
Corpus Christi, TX 78412-5730
361-825-3864
361-825-5871 Fax
Jennifer.Escamilla@tamucc.edu