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Westchester County Department of Correction

RETURN TO DUTY
MEDICAL CERTIFICATION OF EMPLOYEE
(NON-WORK RELATED) ILLNESS /INJURY

Part 1

The attendance policy of the Department of Correction requires evaluation and completion of this form after 72 hours of absence from duty.

Employee: Bring this form with you on the day of your scheduled appointment, or have your physician fax the form to Occupational Health Center (OHC) at (914) 493-1389.

TO BE COMPLETED (BY EMPLOYEE):

Name of Employee: ______________________ **D.O.B** ____________

Division: ______________________ **Squad:** ____________ **Shift:** ____________

Home Phone#: ____________ **E-Mail(Optional):** ______________________

Reason For Absence From Work: ______________________

Absent From Work Since (Give Date): ______________________

Prior History or Similar Condition(s): ______________________

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Any Other Significant Medical History (If Yes, Please Explain): ____________

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Consent & Release (To Be Completed By Employee):

I authorize Occupational Health Center (OHC), to conduct a fitness for duty evaluation on behalf of my employer, the Westchester County Department of Correction. I further authorize all Doctors, Health Care Providers, Clinic, Hospitals, Laboratories and Pharmacies to release to OHC any medical records, reports, histories, test results; and pharmacy records which may be required for my evaluation. I also authorize any physicians, health care providers, employees and agents who work for OHC to disclose these results to my employer or its designated agent.

______________________________ ____________

Signature of Employee **Date**

TO BE COMPLETED (BY EMPLOYEE'S PHYSICIAN):

Date(s) of Illness or Personal Injury: ______________________

Diagnosis: ______________________

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Prognosis: ______________________

When Should Employee Return to Duty: ______________________

List Any Restrictions, Duration of Restrictions and Reason(s) ____________

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Practitioner Name and Title (Please Print): ______________________

Office Address: ______________________

Office Telephone# ____________ **Office Fax#** ____________

______________________________ ____________

Signature of Practitioner **Date**

If Additional Space is Necessary Please Attach Progress Note - Thank You

Westchester County
Department of Correction

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(NON-WORK RELATED) ILLNESS /INJURY

PART 2

Name of Employee: ______________________________

Findings and Determination (To Be Completed by OHC):

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______________________________ **Signature of OHC Practitioner**

______________________________ **Date**

To Be Completed By Deputy Commissioner:

- ☐ **Return to Full Duty Without Restrictions.**
- ☐ **Return to Duty With Restrictions (As Per Above).**
- ☐ **Other:** ______________________________

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______________________________ **Signature of Deputy Commissioner**

______________________________ **Date**