City of Oak Harbor
Doctor's Release to Return to Work / Certification of Illness or Injury

For you to have your physician disclose the below medical information to the City of Oak Harbor, you need to authorize the release of your private medical information in accordance with HIPAA Privacy Regulations. Ask the staff at your physician's office or hospital to provide you with their form.

Employee's Name: _____ Job Title/Dept: _____

ATTENDING PHYSICIAN'S STATEMENT

I hereby certify that _____ was attended by me professionally on
(name of patient)
_____ . At that time the patient was suffering illness or disability as follows:
(date)

_____

_____

_____

_____

_____

_____

Was this a work-related injury? ☐ Yes ☐ No

My recommendations concerning the patient's returning to work and performing essential functions of the job are as follows:
(patient's job description enclosed)

Return to work in employee's regular capacity with no restrictions. ☐

Return to work with the following restrictions: ☐

_____

_____

_____

_____

_____

_____

The restrictions above (if applicable) shall continue:

☐ For _____ days. ☐ From _____ to _____
(date) *(date)*

Until checked by physician in _____ days/weeks. Date of appointment: _____

☐ Permanently

_____ _____
Name of Health Care Provider Signature of Health Care Provider

_____ _____
Address City, State, Zip

_____ _____ _____
Phone Fax Date

Form can be faxed or mailed to:
City of Oak Harbor Human Resources ● 865 S.E. Barrington Drive ● Oak Harbor, Washington 98277-4092
Office: (360) 279-4509, 4518 or (360) 914-7739 ● Fax: (360) 279-4559 or 1-844-279-4559