Health Services
7060 Camp Bowie Boulevard, Fort Worth, Texas 76116
OFFICE 817.814-2990
www.fwisd.org

Fort Worth INDEPENDENT SCHOOL DISTRICT

RETURN TO WORK INFORMATION FORM

Employee to Complete Form

Basic Information: *(please print and complete all fields)*

Employee Name:

Employee ID:

FWISD Email:

Contact Phone Number:

Job Title:

Last Working Day:

Department/Campus Name: **Number:**

Supervisor Name/Phone Number:

Return to Work

An employee granted leave for a personal medical reason must report to and receive clearance from the Health Services Department before returning to work. The employee must have a health-care provider's written statement or release confirming the specific dates of the illness, restrictions, if any, and the date the employee may return to work.

Medical Restrictions

Employees who have medical restrictions must report to the Health Services Department. The employee must have a health-care provider's written statement listing the employee's specific restrictions, limitations, and the duration of restrictions. When restrictions are expected to last less than six months, Health Services in conjunction with the employee's supervisor will make the final determination as to whether the employee will be permitted to return to work with restrictions. If the restrictions are recommended for more than six months or permanent, the employee will be referred to Leaves and ADA Management.

For additional information, reference District Board Policy DEC available at:
https://pol.tasb.org/PolicyOnline/PolicyDetails?key=1101&code=DEC#regulationsTabContent.

1. Has the employee been absent for ten (10) or more consecutive work days?
   - ☐ Yes
   - ☐ No

2. Is the employee now able to perform the essential functions of his or her job that he or she could not previously perform because of the serious health condition for which the employee has been on leave?
   - ☐ Yes, without restrictions
   - ☐ Yes, with restrictions effective until _____ *(indicate date)*

3. Date to report to work location: _____

SIGNATURE

SIGNATURE OF EMPLOYEE

DATE

Submit the completed form and healthcare provider's release to emp.health@fwisd.org as an email attachment.