EMPLOYEE & LABOR RELATIONS OFFICE (ELRO)
CERTIFICATE OF MEDICAL RELEASE

Please return completed form to: Prince George's County Public Schools,
ATTN: Director of Employee and Labor Relations,
14201 School Lane, Room 210. Upper Marlboro, MD 20772
Phone: 301-952-6315. FAX: 301-952-6187. E-mail:elro.investigation@pgcps.org

An employee must submit a Certificate of Medical Release within ten (10) business days of a request by ELRO to be considered for return to duty from Administrative Leave or Temporary Placement following threatening behavior, behavior that presents concern for safety and/or behavior that may make them unfit for duty. *An employee cannot return to work without this release.* Failure to return this form may result in placement in Leave Without Pay status and/or disciplinary action up to and including termination.

Section I: TO BE COMPLETED BY ELRO: Please complete Section I before giving this form to the employee. (**Summarize the facts of the referral incident, and attach a copy of the employee's position description**).

SECTION II: TO BE COMPLETED BY THE EMPLOYEE: Please complete Section II before giving this form and attachment(s) to your health care provider. ***Your signature below also authorizes your healthcare provider to discuss matters relevant to this form with Employee and Labor Relations staff.***

Employee's Name_____ EIN:_____
First Middle Last

Position Title: _____ Work Organization/Location:_____

Employee's Signature: _____Home Phone #:_____ Cellular # _____

SECTION III: TO BE COMPLETED BY THE TREATING HEALTH CARE PROVIDER ONLY: ***As a condition to return to work, the employee must have a medical and/or psychological release. Please complete this form before the employee can resume the job duties identified in the attached position description.***

1) Today's Date_____ Date employee may return to work:_____

2) Period you treated the employee for a medical or psychological condition:
Beginning Date: _____ End Date:_____

3) The patient is released to: **(Please select only one)**

- Never return to work
- Return to full duty without restrictions
- Return to full duty with restrictions which may require workplace accommodations and should be referred to the appropriate entity within your school system.

I declare under penalty of perjury that I have examined all the information on this form and any accompanying statements or forms, and my declaration 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 #_____

Health Care Provider's Practice Name (if applicable): _____

Provider's Business Address:_____

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

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