FORM C
HEALTH CARE PROVIDER'S CERTIFICATION
OF ABILITY TO RETURN TO WORK

1) I hereby certify that I have physically examined_____

(name of employee) and have determined that he/she is able to resume all the essential functions of his or her job with Delaware County as of _____ (date).

2) I received and reviewed the employee's job description: ☐ Yes ☐ No

3) Health Care Providers Contact Information and Signature

_____ _____

Health Care Provider Printed Name Health Care Provider Signature

_____

_____

Health Care Provider Address

_____ _____

Telephone Number Date

Return to: Delaware County
Human Resources Department
10 Court Street, 2nd Floor
Delaware, Ohio 43015
Fax: 740/833-2119
Email: Brad Euans at beuans@co.delaware.oh.us