



**County of Glenn**  
**RETURN TO WORK AUTHORIZATION**

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**Employee's Name:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

The above referenced employee is eligible to return to work (please check one):

\_\_\_\_\_ WITHOUT Restrictions

\_\_\_\_\_ WITH Restrictions

If work RESTRICTIONS (physical/mental) exist, please specify the employee's Work Restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the employee taking any medication which restricts their ability to perform the essential functions of their job?

(circle one) YES or NO

SPECIFIC DATE of next doctor's appointment: \_\_\_\_\_

Health Care Provider – Signature: \_\_\_\_\_

Health Care Provider – Printed Name: \_\_\_\_\_

*For questions regarding this form, please contact the Glenn County Personnel Department at (530) 934-6451.*

County of Glenn – Personnel  
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