 Form GARH-8

**RELEASE TO RETURN TO WORK**

**Instructions to Employee: Prior to returning to work, you must have this form completed by your physician. Please submit the completed document to the Benefits Office. You may not return to work until you have been contacted by the Benefits office.**

**To Be Completed By Physician:**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee's Name: |  |  |  |
|  | First | Middle | Last |

|  |  |
| --- | --- |
| Social Security Number: XXX-XX- |  |

|  |  |  |
| --- | --- | --- |
| Date of Disability: |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diagnosis: |  |  | Work Site: |  |

Employee May Return to Work **Without** Restrictions: **(based upon attached job description)**

|  |  |
| --- | --- |
| On: |  |

Date

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

Physician’s Signature Physician’s Name (Print or Type)

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

Date Office Street Address

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

Office Telephone Number City, State, Zip Code

Submit completed form to: **COBB COUNTY SCHOOL DISTRICT**

**BENEFITS OFFICE/HUMAN RESOURCES**

**P.O. BOX 1088**

**MARIETTA, GEORGIA 30061**

**Phone: (770) 426-3537 Fax: (678) 594-8580**