



Newark Board of Education

Dr. Yolanda Méndez
Assistant Superintendent of Human Resource Services

Where Passion Meets Progress

Return to Work Medical Certification

Part 1: To Be Completed By Employee (please print)

Employee Name: _____ ID# _____
(First Name, Last Name)

Employee Position: _____ Leave Start Date: _____

Employee Signature: _____ Date: _____

Part 2: To Be Completed By Employee's Health Care Provider

I certify that on _____, _____, is able
(Date) (Name of Employee)

to resume performing the functions of his/her position without reasonable accommodation.

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Stamp:

If you have any questions or need information, please feel free to call 973-733-6565 or 973-688-2687 to speak with a HR representative or email at leaveofabsence@nps.k12.nj.us.