

COLUMBUS STATE COMMUNITY COLLEGE
COLLEGE HEALTH OFFICE

PHYSICIAN'S CERTIFICATION FOR RETURN TO SCHOOL
FOLLOWING ILLNESS, INJURY, OR HOSPITALIZATION

In order to assure that a student is able to return to school without complications, the student's personal physician is requested to complete this form indicating the student's abilities or limitations.

STUDENT NAME: _____

PROGRAM: _____

Please state the general nature of this student's current medical condition or limitations. If this is a pregnancy, please give the EDC.

_____ This student may return to/remain in his or her classes or clinical assignments without restriction.

_____ This student may return to /remain in his or her classes and clinical assignments with the restrictions listed below. (If the student has personal lifting restrictions, please state if the student would be able to perform these tasks with the assistance of another person: moving a client up in bed with assistance; turning a client in bed with assistance; transferring a client from bed to chair or cart and back to bed with assistance, and similar activities).

Specify restrictions: _____

These restrictions are in effect until this date: _____

_____ This student may not return to classes or clinical assignments until:

Comments: _____

Physician's Signature: _____ Date: _____