RETURN TO DUTY FORM:

COVID-19 INFECTION MEDICAL CLEARANCE RELEASING THE COACH OR STAFF MEMBER TO RESUME FULL ATHLETIC RELATED DUTIES

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) before the coach or staff member is allowed to resume full athletic related duties: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP).

Name of Coach/Staff Member:_____ DOB:_____ Male/Female

Date COVID-19 Infection Diagnosed:_____

This is to certify that the above-named coach or staff member has had medical assessment for COVID-19 infection.

As the examining LHCP, I have thoroughly assessed the above-named coach/staff member (including review of appropriate diagnostic studies if indicated) and have determined that this individual is medically cleared. Therefore, by signing below, I give the above-named coach/staff member consent to resume full athletic related duties.

_____ _____

Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle) — Date

_____

Please Print Name

_____ _____

Please Print Office Address — Phone Number

Rev October 27 2020