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: ___________ Date COVID-19 Infection Resolved: ___________

This is to certify that the above-named coach or staff member has been diagnosed and treated 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 they are medically cleared to return to athletic duties. By signing below therefore, 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

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