Shelby County Schools
Department of Human Resources
Office of Employee Benefits

REINSTATEMENT FORM

I understand that prior to my return from leave and reporting to my assigned location, I must report to the SCS Office of Employee Benefits five (5) business days prior to the end of my approved leave of absence. This form must be signed by the Leave Administrator for written clearance.

If you are released to return back to work earlier than anticipated; you must submit a statement from your physician indicating the revised return to work date.

If you have been released by your physician to return to work with restrictions; you must submit a statement from your physician identifying the limitations and the timeframe (specific dates) in which limitations are effective.

I understand by signing this form, I have read and understand the terms of condition for returning to work from my approved leave of absence. **Additionally, I understand that failure to comply may result in a delay of the processing of my leave return which could affect my paycheck or employment status.**

Please Print:

Employee's Name: _____ Social Security Number: ____ - ____ - ____

Current Location Name: _____ Current Job Title: _____

Date to Return to Work: _____ / _____ / _____

_____ _____ / _____ / _____
Employee's Signature **Today's Date**

_____ _____ / _____ /_____
*(Required)***Leave Administrator's Signature (The Office of Employee Benefits)** **Today's Date**

CC: Principal/Supervisor