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# RETURN TO WORK CERTIFICATION

**Instructions:**

1. Employee: Fill out SECTION I of this form, attach your current job description (available from your manager), and submit them to your health care provider.
2. Health Care Provider: Complete SECTIONS II and III then return form to the employee for submission.
3. Employee: Submit the completed certification form to the appropriate administrator.

## SECTION I. EMPLOYEE INFORMATION

| | | |
|---|---|---|
| Employee Name: | Employee ID: | Campus Phone: |
| Current Mailing Address: | | Home Phone: |
| Department Manager: | Division/Unit (College/Dept.) | Manager Phone: |

## SECTION II. HEALTH CARE PROVIDER TO COMPLETE THE REMAINDER OF THIS FORM

Is the employee able to perform all the essential functions of this job? ☐ Yes ☐ No

If no, list any restrictions or describe accommodations the department should consider:

The restrictions are: ☐ Permanent
☐ Temporary until (Specify date): _____

Date employee is to return to work: _____

## SECTION III. HEALTH CARE PROVIDER INFORMATION

| | |
|---|---|
| Name: | Specialty: |
| Address: | Phone Number: |
| State License Number: | Licensed to practice in the state(s) of: |
| Signature: | Date: |