RETURN TO WORK / MEDICAL VERIFICATION FORM

EMPLOYEE TO COMPLETE

Employee Name: _____ **Date of Birth**_____

Home Address: _____

City: _____ **State:**_____ **Zip:** _____

Home Phone No.:_____

Job Title: _____ **Department:** _____

Supervisor: _____

Employees who are absent from work for more than five consecutive days, are involved in a work-related accident or incident, or who are requested must submit this Return to Work / Medical Verification form to their supervisor before returning to work. Further, the employee must execute the Release of Information on Page 2.

If illness or injury was treated by more than one provider A RETURN TO WORK FORM MUST BE SUBMITTED FOR EACH TREATMENT PROVIDER prior to returning to work.

PHYSICIAN / PROVIDER CERTIFICATION

This is to certify that the patient named above has been under my professional care. I prescribed his/her absence from work starting on _____ through and including _____.

Patient may return to work on _____ with no restrictions.
OR
Patient may return to work on _____ with restrictions explained more fully on the Page 2.
OR
Patient will be reevaluated on_____ and should remain off work until released.

I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. Concord University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether the accommodation can be met in a reasonable fashion.

Print Treatment Provider's Name/Certification (D.O. M.D., etc.):

Address:

City/State/Zip:

Phone Number: Fax Number:

_____
Treatment Provider's Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize Concord University to obtain and my medical provider(s) to release any medical documentation necessary to process my request for leave or release to return to work.

Leave determinations and requests include Worker's Compensation, Family Medical Leave Act, Parental Leave Act, ADA, medical leave of absence without pay, use of sick leave and Catastrophic Leave. The use of Sick or Annual Leave or any other approved leave will be determined with consideration of the information provided by the certifying provider.

I understand Concord University may also seek medical information from me or my treatment provider(s) in order to assess employability options including accommodation or restriction from work.

A copy of this document may be accepted the same as an original.

_____ _____
Employee Signature Date

RESTRICTIONS

_____ is released to return to work on_____
with the following **restrictions**:

Hours per day: 0 Normal Schedule 0 Limited Please Specify_____

Days per week: 0 Normal Schedule 0 Limited Please Specify_____

Restrictions during a work shift

Bending/Stooping	0	0 hours	0	1-3 hours	0	3-5 hours	0	5-8+ hours	0	No restriction
Pulling/Pushing	0	0 hours	0	1-3 hours	0	3-5 hours	0	5-8+ hours	0	No restriction
Overhead Reaching	0	0 hours	0	1-3 hours	0	3-5 hours	0	5-8+ hours	0	No restriction
Sitting	0	0 hours	0	1-3 hours	0	3-5 hours	0	5-8+ hours	0	No restriction
Standing	0	0 hours	0	1-3 hours	0	3-5 hours	0	5-8+ hours	0	No restriction

If other limitations, please specify: