



RETURN TO WORK FORM

900 S. Crouse Avenue, 005 Steele Hall - 443-5367
119 Euclid Avenue Rm 107 - 443-5106

Name of Employee: _____

Today's Date: _____

Department: _____

Job Title: _____

SUID#: _____

Last Day Worked: _____

Department Job Analysis: Brief description of job tasks to be completed by supervisor:

Chemical, Tools, Equipment, Machines Used:

Physical Demands: Based on percentage of time required during the day, please note frequency as follows:

Constant (up to 100%)

Occasional (10% to 33%)

Never (0%)

Frequent (34% to 67%)

Rare (Less than 10%)

Standing		Kneeling		Handling/Fingering	
Walking		Crouching		Reaching Forward	
Sitting		Crawling		Concentration	
Pushing		Twisting		Work/Deadline Pressures	
Balancing		Climbing Stairs		Typing/Keying	
Stooping		Reaching Overhead			

Lifting and Carrying: Indicate the maximum amount of weight the employee is expected to handle by placing an X in the appropriate box.	10 lbs	20 lbs	50 lbs	75 lbs	100 lbs
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Type of Leave:

NYS Disability or Workers Compensation – Contact Risk Management at 443-4011 (Fax: 443-1154)

Salary Continuation – Contact Dana Butler, Office of Equal Opportunity, Inclusion and Resolution Services at (Fax: 443-5021)

Supervisor Name: _____

Contact Number: _____

Signature: _____

Date: _____

Physician's Assessment:

I have reviewed the above employee's job requirements and my patient is:

Approved to return to work on: _____ (date)

Approved to return to work with modifications as follows: _____

Duration of modifications: _____

Not approved to return to work until: _____ (targeted return to work date)

Physician's Signature _____

Date: _____

NOTE: The physician's office must fax this form

to the appropriate department as noted above.

