**MEDICAL CERTIFICATION RETURN TO WORK**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Physician,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , an employee of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of the Archdiocese of Miami, has been absent from work from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and we have requested a certification from her/his health care provider.

Kindly review the attached job description for this employee, complete this form, and return it to me.

**Please answer the questions below to help determine disability and reasonable accommodation.**

1. What date did the condition begin?

**Please check one of the following:**

**\_\_** The employee is able to work a full, regular schedule with no restrictions, beginning \_\_\_\_\_\_\_\_\_\_\_ (date)

\_\_ The employee is unable to return to work until \_\_\_\_\_\_\_\_\_\_ (date)

\_\_ The employee is able to return to work on a reduced schedule for \_\_\_ hours per day from \_\_\_\_\_\_\_\_\_ (date) through \_\_\_\_\_\_\_\_\_\_ (date)

\_\_ The employee is able to return to work with restrictions from \_\_\_\_\_\_\_\_\_ (date) through\_\_\_\_\_\_\_\_\_ (date).

**Please indicate restrictions, if any, below for:**

Standing (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walking (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lifting (number of pounds): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carrying (number of pounds): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of hands (repetitive motions, pushing, pulling): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other restrictions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN SIGNATURE / DATE:**

Physician Name and Address:

Physician License Number:

Please send completed form to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and indicate Medical Certification RTW in subject line.

Signature of ADOM Administrator or Manager requesting information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO BE COMPLETED BY OFFICE OF HUMAN RESOURCES ONLY:

Office of Human Resources Signature / Date:

Comments: