

The purpose of this form is to have the employee and/or their medical records reviewed by the University Physician to determine if they are able to return to work. Please complete the top portion of this form and send it to the University Physician, 107 Olin Health Center. To schedule an appointment, call Linda Seppala at 353-9101.

RETURN TO WORK VERIFICATION

EMPLOYEE: _____

JOB TITLE: _____ DEPARTMENT: _____

NATURE OF INJURY/ILLNESS: _____

WORK RELATED INJURY/ILLNESS: Yes No ONSET DATE: _____

PERSON REQUESTING RELEASE: _____ PHONE: _____

SIGNATURE: _____

XX

TO BE COMPLETED BY UNIVERSITY PHYSICIAN

1. Employee can return to regular position without restrictions on _____.

2. Employee can return to work with restrictions, related to _____ injury/illness on _____.

- a. Weight (specify)
- b. Setting (indoor/outdoor)
- c. Length/time of work (hours per day or week)
- d. Mobility
- e. Other limitations (please specify)

3. Is this a good candidate, from a medical standpoint, for alternative work placement?
(Check one) Yes No Not Applicable

4. What are the job conditions that would be suitable with this workers' current limitations?

Indoor

Outdoor

Sedentary

Active

Hours

Other

Not Applicable

5. Accommodations needed (please specify)

6. These restrictions are/are not related to a work related injury/illness.

7. Employee can not return to work. This is/is not related to work injury/illness.

University Physician Signature

Date

In order to determine your suitability for University employment, we request you sign this release form. This is not intended to invade your privacy.

I, _____, authorize the University Physician to discuss my medical condition with the appropriate university personnel for the purpose of my return to work.

Signed _____

Witness _____

Date _____