Seattle University
Medical Certification- Return-to-Work Form

This Return-to-Work form is required when **all** of these conditions matching your leave are true:

A. You are on a medical leave for your own serious health condition.
B. Your medical leave is continuous (not an intermittent medical leave).
C. At least one of these are true:
- Your actual Return Date is different than your originally requested Return Date, **or…**
- You are released back to work with physical restrictions or schedule modifications.

Employee Instructions

- Complete **Section 1** of this form with your name and SeattleU identification number prior to presenting to your health care provider.
- Discuss your essential job functions or share a copy of your current Job Description (obtained from Human Resources) with your health care provider.
- Submit this completed form to Human Resources (contact information below) prior to returning from leave.
- During your leave, keep in contact with your supervisor and Human Resources if the duration of the leave or other criteria changes.
- Failure to submit this certification prior to returning to work may result in:
  - Loss of FMLA designation
  - Impact to your pay
  - Delayed return-to-work
  - Your position being posted and/or filled

Healthcare Provider Instructions

- Complete **Section 2** and **Section 5**, as well as **Sections 3 & 4** if applicable.

- Ensure form is completed with sufficient information identifying:
  - Release to full duty (no restrictions) **or**
  - Release to modified duty, specifying:
    1) The estimated frequency/duration of intermittent absences (if any), **and/or**
    2) If a part-time/reduced schedule is needed, **and/or**
    3) If there will be any *restrictions* upon returning that may affect the employee's essential job functions.

- If there are physical restrictions, in **Section 3** please identify if those restrictions are "Temporary" or "Permanent".

Contact Information

Seattle University Human Resources- Leaves of Absence

Email: leaves@seattleu.edu
Phone: (206) 296-5870
Fax: (206) 296-2100

Medical Certification-Return to Work Form

To be completed for Non-Work-Related Illness/Injury

Section 1 – To be completed by Employee

Employee Name:	**SeattleU ID #:**	**Visit Date:**
Name of Healthcare Provider (Print)**:**	**Phone:**	**Fax:**

Employee's normal work schedule: Hours per day_____ Days per week_____Regular shift (Day/Eve/Night)_____ On Call?_____

Section 2 – Work Status – To be completed by Health Care Provider

☐ Released to **Full Duty** without any restrictions on: _____ / _____ / _____.

➢ Send to Leaves of Absence (see Page 1).

☐ Released to work with **physical restrictions** on: _____ / _____ / _____.

➢ Send form to Job Accommodation (see Page 1).

Should the employee work a part-time or reduced schedule? ☐ No ☐ Yes (If yes, complete the fields below and send the form to Leaves of Absence.)

Maximum hours per day: _____ Maximum days per week: _____ In effect from: _____ / _____ / _____ through _____ / _____ / _____.

Will the employee have absences for treatment appointments? ☐ No ☐ Yes (If yes, complete the fields below and send the form to Leaves of Absence.)

Estimate the treatment schedule (please include time required per appointment): _____.

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes (If yes, complete the fields below and Send the form to Leaves of Absence.)

Frequency: _____ episodes per _____ week(s) _____ month(s)

Duration: _____ hours per episode – OR – _____ days per episode

Section 3 – Physical Capacities – To be completed by Health Care Provider

☐ The **temporary physical restrictions** below are in effect from: _____ / _____ / _____ through _____ / _____ / _____.

☐ The **physical restrictions** below are **permanent.**

Physical Capacities		**Never**	**Seldom** 1 – 10% 0 – 1 Time per Hour	**Occasional** 11 – 33% 1 – 3 Times per Hour	**Frequent** 34 – 66% 3 – 6 Times per Hour	**Constant** 67 – 100% Not Restricted
Sit						
Stand / Walk						
Climb Ladders (Stairs, Ladders, etc.)						
Twist						
Bend / Stoop						
Squat / Kneel						
Crawl						
Reach	L R B					
Work Above Shoulders	L R B					
Work Below Shoulders	L R B					
Keyboard	L R B					
Wrist Flexion/Extension	L R B					
Forceful Grasp	L R B					
Pinch	L R B					
Fine Manipulation	L R B					
Operate Foot Controls	L R B					
Vibratory Tasks	L R B					
Repetitive Motion Task						
Rotation of Head / Neck						
Sensory Demands (Hearing/Seeing/Talking)						
Example		*50 lbs.*	*20 lbs.*	*10 lbs.*	*10 lbs.*	*0 lbs.*
Lift	L R B					
Carry	L R B					
Push	L R B					
Pull	L R B					

Medical Aids/Equipment

Does patient require medical aids (e.g. crutches, splint, brace) or personal protective equipment (e.g. gloves, mask)? ☐ No ☐ Yes

If Yes, s*pecify:* Please provide necessary details about any restrictions occurring in which medical aids are in place. Typically, it is not necessary to provide diagnosis or treatment information.

Section 4 – Cognitive/Emotional Capacities – To be completed by Health Care Provider

Basic Work

Follow verbal instructions?	☐ No	☐ Yes
Follow written instructions?	☐ No	☐ Yes
Maintain workflow & pace?	☐ No	☐ Yes
Follow established work and safety procedures?	☐ No	☐ Yes

Attention to Detail/Tasks

Perform simple or repetitive tasks?	☐ No	☐ Yes
Perform complex or varied tasks?	☐ No	☐ Yes
Organize tasks and set priorities?	☐ No	☐ Yes
Perform or direct multiple tasks simultaneously?	☐ No	☐ Yes

Interaction with Others

Follow verbal instructions?	☐ No	☐ Yes
Follow written instructions?	☐ No	☐ Yes
Maintain workflow & pace?	☐ No	☐ Yes
Follow established work and safety procedures?	☐ No	☐ Yes

Decision-Making

Give training or instruction?	☐ No	☐ Yes
Use basic-problem-solving techniques?	☐ No	☐ Yes
Make independent judgements & decisions?	☐ No	☐ Yes

Comments/Clarification:

Section 5 – Health Care Provider Signature

Next Scheduled Visit:_____/_____/_____. If unknown, please estimate:_____Days_____Weeks

Print Name : _____

Signature:_____Date:_____/_____/_____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Seattle University asks that the health care provider not provide any genetic information when responding to requests for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.