MIAMI UNIVERSITY
DEPARTMENT OF HUMAN RESOURCES
Employee & Labor Relations

15 Roudebush Hall
501 East High Street
Oxford, OH 45056
513-529-2027 (P)
513-529-2686 (F)

RETURN TO WORK CERTIFICATION

This certification must address the employee's ability to perform the essential functions of the employee's job. Please print and complete the form in its entirety. Fax to the attention of Becky Wilp, f: 513-529-2686.

EMPLOYEE INFORMATION

Name: _____

HEALTHCARE PROVIDER INFORMATION

Provider's Name: _____

Provider's Business Address: _____

Provider's Business Phone: _____

Provider's Business Fax: _____

Medical facts/condition: (include approximate date condition commenced):

_____

_____

_____

List specific dates(s) you treated the patient for the condition:

_____

If provided, please review the attached job description for the following questions.

In your medical opinion is the employee able to perform the job functions due to the condition?

_____

Is the employee **unable** to perform any of their job functions due to the condition? □ YES □ NO

If YES, identify the job functions the employee is **unable** to perform: _____

_____

_____

_____

Are there any other relevant medical facts related to the condition (such medical facts may include symptoms, diagnosis, or any regiment of continuing treated such as use of specialized equipment)?

_____

_____

_____

Is the employee able to return to work? □ YES □ NO

If YES, what date is the employee able to return? _____

Will any additional FML be necessary to support the employee's current medical condition? □ YES □ NO

If YES, please detail:

_____

_____

_____

Estimate the treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including recovery time:

_____

_____

_____

Will the condition cause episodic flare ups periodically preventing the employee form performing their job function? □ YES □ NO

If YES, please detail:

_____

_____

Does the employee have a physical restriction(s)? □ YES □ NO

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	Can't perform at all	Can perform occasionally	Can perform frequently	Can perform continuously
Lift/Carry Up to 10 lbs.				
11 – 20 lbs.				
21 – 50 lbs.				
51 – 100 lbs.				
Bending				
Twist/turn				
Reach below the knee				
Push/pull				
Squat/kneel				
Stand/walk				
Sit				
No lifting above Shoulders				

How long will the employee likely be under these restriction(s)? (Date)_____

Healthcare Provider's Signature:_____ Date signed:_____