EMPLOYEE'S RETURN TO WORK CERTIFICATION FORM

**CERTIFICATION MUST BE RETURNED TO THE COMPANY PRIOR TO ALLOWING THE EMPLOYEE TO RETURN TO WORK. FAILURE TO RETURN THE COMPLETED FORM PRIOR TO AN EMPLOYEE'S INTENDED RETURN TO WORK DATE MAY RESULT IN A DELAYED REINSTATEMENT OF THE EMPLOYEE.*

SECTION I: TO BE COMPLETED BY EMPLOYER

Employer Name: **University of San Francisco** Employer Contact: **Jill Bouchard**

Employee's Name: ____________________

Employee's Position: ____________________ Employee's Regular Work Schedule: ____________________

Status: ☐ Full-Time ☐ Part-Time On leave since: ____________________

A Job Description, which contains a list of the patient's essential job functions ☐ is attached, ☐ is not attached.

SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient has been on leave due to a serious health condition and/or other medical condition. Please answer, fully and completely, all applicable parts of this certification form. Your answers to the questions below should be limited to the condition for which the employee has been on leave. In other words, the certification should certify whether the employee is able to return to work and can perform the essential functions of his or her job as they relate to the employee's condition that necessitated the leave.

To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and California Genetic Information Nondiscrimination Act of 2011 (Cal GINA), do not provide genetic information in response to this request. "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, information regarding the manifestation of a disease or disorder in a family member of the individual, the fact that 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.

PLEASE *DO NOT* STATE OR IN ANY WAY INDICATE THE SPECIFIC NATURE OF THE HEALTH OR MEDICAL CONDITION OR DIAGNOSIS ANYWHERE ON THIS DOCUMENT WITHOUT THE PATIENT'S CONSENT.

Effective as of _________________________ the above named patient is hereby certified as fit to return to work duties as follows:

☐ Full-time duties, no restrictions

☐ Full-time duties, with the following restrictions (conditions and duration):

____

____

____

____

☐ Part-time duties, no restrictions

☐ Part-time duties, with the following restrictions (conditions and duration):

____

____

____

____

☐ Intermittent duties, with the following restrictions (conditions and duration):

____

____

____

Additional comments, if any:

____

____

____

____

Provider's Name: ____

Provider's Business Address: ____

Type of Practice/Medical Specialty: ____

Telephone: ( ) Fax: ( )

Signature of Provider: ______________________________ Date: ______________

If you have any questions, please contact the Company's Leave Administration/HR department:

Jill Bouchard
jkbouchard@usfca.edu
PH 415.422.4801
FAX 415.422.4437
2130 Fulton Street
Lone Mountain Room 339
San Francisco CA 94117

Medical Office Stamp____