MEDICAL CERTIFICATION FORM

Employee Name: Unit/Job Title:

Health Care Provider Name: Title:

Health Care Provider Address and Phone Number:

RETURN TO WORK FULL DUTY WITH NO RESTRICTIONS? YES NO DATE:

Is this Condition: _____ Temporary _____ Permanent

Date the Condition Began: | Date Return to Work:

Does this condition allow the employee to perform the Essential Functions of this job? _____YES _____ NO

If not, please describe what **temporary restrictions** or **permanent accommodations** are needed for which essential function. Use an additional page if needed.

(Complete this section only if requesting permanent accommodations under the Americans with Disabilities Act.) Describe nature of disability, major life functions affected, functional limitations and prognosis.

The following details the employee's current capabilities for evaluation of MODIFIED WORK ONLY: (please check as appropriate)

	1 to 2 lbs	3 to 5 lbs	6 to 10 lbs	11 to 20 lbs	21 to 30 lbs	31 to 40 1bs	41 + lbs
Lifting							
Carrying							
Push/Pull							

	Minimal	Under 1 Hr	1-2 Hrs	2-3 Hrs	3-4 Hrs	4-5 Hrs	5-6 Hrs	8 Hrs
Sitting								
Standing								
Walking								

	YES	NO
Squatting		
Bend/Twist at Waist		
Reaching		
Work above Shoulder		

Restrictions effective until (date):

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Health Care Provider's Signature: _____ **Date:** _____