RETURN TO WORK CERTIFICATION

EMPLOYEE

Employee Name:

Name of School or Department:

Position:

Supervisor:

PHYSICIAN: COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO HUMAN RESOURCES PRIOR TO RETURN TO WORK DATE:

Have you reviewed the employee's job description? ☐ Yes OR ☐ No

Do you recommend the employee return to work?

☐ No

☐ Yes, with restrictions or accommodations

☐ Yes, without restrictions or accommodations (Full Duty)

Please list any restrictions or describe accommodations including schedule changes which the department should consider.

Physical Evaluation

Are the restrictions: ☐ Permanent OR ☐ Temporary **If temporary, until when?** _____

Types of Restrictions:

Lifting ☐ 0-10 pounds ☐ 10-20 pounds ☐ 20-50 pounds ☐ 50-100 pounds

Bending _____ Kneeling _____ Stooping _____

Twisting _____ Standing _____ Walking _____

Sitting _____ Climbing _____ Reaching _____

Repetitive Motion _____ Grasping _____ Cognitive _____

Other _____

_____

Behavioral Evaluation

	Able to perform	Other Considerations (please specify)	Not Able to perform
Understanding			
Remembering			
Sustained concentration			
Follow-through on instructions			
Decision making			
Relating to co-workers and students			

Comments:

Employee is released to return to work effective:

Name of Health Care Provider:

Specialty: Phone number: Fax number:

Address of Health Care Provider:

_____

Signature of Health Care Provider Date

Risk Management Contact Information:

Fax: 405.587.0148

Riskmgmt@okcps.org