SJSU | UNIVERSITY PERSONNEL

RETURN TO WORK CERTIFICATION

Instructions:

1. Employee: Fill out SECTION I of this form, attach your current job description (available from your manager), and submit them to your health care provider.
2. Health Care Provider: Complete SECTIONS II and III then return form to the employee for submission.
3. Employee: Submit the completed certification form to the appropriate administrator.

SECTION I. EMPLOYEE INFORMATION		
Employee Name:	Employee ID:	Campus Phone:
Current Mailing Address:		Home Phone:
Department Manager:	Division/Unit (College/Dept.)	Manager Phone:

SECTION II. HEALTH CARE PROVIDER TO COMPLETE THE REMAINDER OF THIS FORM

Is the employee able to perform all the essential functions of this job? ☐ Yes ☐ No

If no, list any restrictions or describe accommodations the department should consider:

The restrictions are: ☐ Permanent
☐ Temporary until (Specify date): _____

Date employee is to return to work: _____

SECTION III. HEALTH CARE PROVIDER INFORMATION	
Name:	Specialty:
Address:	Phone Number:
State License Number:	Licensed to practice in the state(s) of:
Signature:	Date: