

FRANKLIN & MARSHALL

Human Resources

P.O. Box 3003, Lancaster, PA 17604-3003

Fax: (717) 291-3969

Medical Leave

Return to Work Certification

Employee's Name: _____

I authorize the following health-related information to be released to Franklin & Marshall College for the purpose of determining eligibility for return to work from medical leave.

(Employee's Signature)

(Date)

TO BE COMPLETED BY THE PATIENT'S HEALTH CARE PROVIDER:

1. Date patient was last seen in your office: _____

2. On what date was the employee / patient first unable to work? _____

3. On what date is the patient able to return to work without risk to self or others? _____

4. (*For communicable illness only.*) In your judgment, is the patient able to return to work on the date indicated above without risk of spreading the communicable illness to others? Yes No

Comments: _____

5. In your judgment, is the patient able to return to work on the date indicated above and safely perform all his/her essential job functions? Yes No

Comments: _____

6. Please describe any applicable work restrictions and expected duration of restrictions:

(over)

Name of Physician or Health Care Practitioner

Name and Address of Practice

Phone Number

Signature of Physician or Health Care Practitioner

Date

All personal health information provided to Human Resources will be kept confidential.

Please return this completed form to Human Resources, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA 17604-3003, or fax to (717) 291-3969.