PAGE 1 OF 2RETURN IMMEDIATELY TO:
Cedarburg School District – Human Resources
Phone: 262.376.6106 Fax: 262.376.6110
W68 N611 Evergreen Blvd. Cedarburg, WI 53012

Return To Work Recommendation
Medical Status Update

Part 1: EMPLOYEE COMPLETES

This form is required to return to work from medical absences due to hospitalization or if greater than 5 days in length

1. Complete Part 1, attach your job description if available, and give this form to your physician to complete Part 2 and 3.
2. Fax completed form to the Human Resources Coordinator (Fax: 262.376.6110) no later than the business day before your return. Provide a copy to your Supervisor/Administrator. Your return to work will be delayed until a medical release is received based upon the essential functions of your job.

Name _____ School _____ Date of Birth _____

Phone _____ Job Title _____

Dates of Absence: _____

Employee's Consent to Release Medical Information

I ____DO ____DO NOT (initial one) voluntarily give my permission to my medical provider to forward this medical document directly to the Human Resources Coordinator who will maintain my medical information confidentially and separate from my personnel file. I understand that it is my responsibility to ensure that this return to work recommendation is received by the Human Resources Coordinator prior to returning to work.

_____ _____

Employee Signature Date

PART 2: PHYSICIAN COMPLETES

☐ Return to Work Recommendation ☐ Medical Status Update

Employees are unable to return to work without this medical release. Please return this form immediately to your patient or with permission from the employee (as indicated above) you may **FAX this form to: 262.376.6110**.

1. The reason for absence: ☐ Illness ☐ Injury ☐ Surgery ☐ On the job injury

Approximate date condition commenced?_____

Was patient admitted for an overnight stay in hospital, hospice, or residential medical facility? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care providers for evaluation or treatment? ☐ Yes ☐ No

2. Did the employee provide you with a **written job description**? ☐ Yes ☐ No (*If no, Complete the Work Ability Chart)*

Did the employee **describe** their job functions? ☐ Yes ☐ No

3. Is the employee able to **perform ALL of the essential function of their job**?

☐ **YES** S/he may **return to Full Duty and Full Time schedule** on _____ *(date)*.

☐ **YES** S/he may **return to Full Duty but a Reduced Work Schedule** on _____ *(date)*.
Describe Reduced Schedule: _____ work hours per day. Return to full schedule on _____ *(date)*.

☐ **NO** S/he **cannot perform ALL functions** of the job. *(Complete Work Ability Chart on page 2.)*
S/he may **return to unrestricted**, **Full Duty** on _____ *(date)*. This is an **estimate**___. This is a **Firm Date**.___.

4. Please answer the following:

a. Date of the next medical evaluation: _____ *(date).*

b. Are any of the restrictions permanent? ☐ Yes ☐ No Please list permanently restricted activities on page 2.

Health Care Provider's Signature

I hereby certify that the facts on this form are true and correct based on my recent examination of the patient. I have read the attached Essential Job Functions before making these determinations.

Health Care Provider's Signature (Stamps or Proxy Signatures are not Accepted) Date

Health Care Provider Name _____

Specialty/ Type of Practice _____ License Number _____

Address _____

Telephone _____ Fax _____

Please complete the following chart if there are job restrictions to be considered.
Please base your response on a recent exam. Describe the employee's current physical and mental abilities.

Part 3 – Work Ability Chart

Activity Limits (Please **circle**, **check**, or **fill in** your response)				**Weight Limit/ Comments**	
Definitions: Occasional: Under 1/3 of work day Frequent: 1/3 – 2/3 of work day	Not at All	Occasional	Frequent	No Restrictions	If restricted, Circle Maximum Weight in Pounds
Lifting	R / L	R / L	R / L	R / L	5-10 11-20 31-40 41-55 No Limit
Carrying	R / L	R / L	R / L	R / L	5-10 11-20 31-40 41-55 No Limit
Pulling/Pushing	R / L	R / L	R / L	R / L	5-10 11-20 31-40 41-55 No Limit
Reach above shoulder	R / L	R / L	R / L	R / L	5-10 11-20 31-40 41-55 No Limit
Hands – Grasping	R / L	R / L	R / L	R / L	
Hands – Fine Manipulation	R / L	R / L	R / L	R / L	
Balancing					
Stooping					
Kneeling					
Driving a vehicle					
Bending/ Squatting	/	/	/	/	
Climbing Stairs/ Ladders	/	/	/	/	

Walking _____ Hours at one time. _____ Hours per day. ☐ No Restrictions

Standing _____ Hours at one time. _____ Hours per day. ☐ No Restrictions

Sitting _____ Hours at one time. _____ Hours per day. ☐ No Restrictions

Work at Computer _____ Hours at one time. _____ Hours per day. ☐ No Restrictions

Mental Concentration _____ Hours at one time. _____ Hours per day. ☐ No Restrictions

Is employee able to respond quickly to physically hazardous situations? ☐ **Yes** ☐ **No**

To restrain aggressive children? ☐ **Yes** ☐ **No**

Describe ***ANY OTHER*** concerns you have about the employee's physical or emotional ability to perform the essential functions of their job. Please also identify any permanent restrictions.