



RELEASE AND RETURN TO WORK MEDICAL CERTIFICATION

Section 1: To be Completed by Employee

Name of Employee: _____ CWID: _____

Contact Phone Number: _____ Last Work Day Before Illness/Injury: _____

Contact Email Address: _____

Medical Release (completed by Patient – Employee):

I authorize my provider to release medical information necessary to process the above request or clarify information regarding the employee’s need for leave, relief from assigned duties, or return to work, to a representative of the District Office of Human Resources. I understand this authorization shall remain in effect for 90 days from the date of my signature.

Patient’s Signature: _____ Date: _____

Print Patient Name _____

Section 2: To be Completed by Medical Provider

I attended the patient for the present medical condition from: _____ to: _____

First day employee was unable to work: _____

This employee is authorized to return to work on the following date: _____

The employee is authorized to return to work: (check one)

WITHOUT limitation(s) (full release) and resume 100% of his/her hours and duties. (Proceed to signature section)

WITH Limitation/s or Restriction/s as described on the next page. (Describe employee’s limitations or restrictions on next page.)

Describe the employee’s physical, environment and mental limitations – as described in the employee’s job description and work activities, or if not specifically provided, as described by the employee.

- 1) *physical effort* – for example, reading, sitting, holding, grasping, walking, talking, bending, squatting, climbing, reaching, pulling/pushing, crawling, lifting, driving, etc.;
- 2) *environmental conditions* – for example, heights, outdoor weather conditions, temperatures, exposure to potential hazard conditions (gases, electricity, etc.), daytime vs. night, noise, etc.; and
- 3) *mental capabilities* - for example, preparing/analyzing figures; memorizing/concentrating; learning/knowledge retention; operate/use devices such as phone or computer; make group presentations; interact with others; self-regulate emotion/behavior; compose information; etc.

[Use next page. Attach additional page if needed]

**PLEASE RETURN COMPLETED FORM TO: Foothill-De Anza Community College District,
District Office of Human Resources, 12345 El Monte Road, Los Altos Hills, CA 94022**

Employee's Ability to Work a Full Schedule – The employee is able to work (regardless of functional limitations that may or may not apply):

- A full work schedule (100%)
- Some but less than a full work schedule *
- None of his/her work schedule

*If the employee is able to work some of his/her work schedule, but less than a full schedule, please explain and describe the extent to which the employee's ability to work a full schedule is limited:

Employee's Ability to Perform the Essential Functions – The Employee is able to perform:

- All of the essential functions of his/her position?
- Some (but less than 100%) of the essential functions? *
- None of the essential functions of his/her position

*If the employee is able to perform some, but less than 100%, of his/her essential functions, please explain and describe the extent to which the employee's ability to perform the functions of his or her job *is limited*:

Duration:

How long will these limitations/restrictions impair the employee's ability to perform 100% of his/her hours *and* duties?

What date is the employee expected to be able to resume 100% of his/her hours *and* duties? _____

PLEASE NOTE: A Medical Certification authorizing return to work WITHOUT LIMITATION (FULL RELEASE) may be required at the time Employee is released to return to 100% of Hours and Duties.

Name of Health Care Provider (Please Print): _____

Licensed Area of Practice or Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone No: _____ Tax ID Number: _____

Health Care Provider Signature: _____ Date: _____

**All medical/health information is maintained in a separate confidential file.
Access to this information is restricted by law to authorized persons only.**

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