University of Northern Iowa

Human Resource Services

RETURN TO WORK CERTIFICATION

Note: This form is used to help determine an employee's return to work status and minimize release of medical information when returning from a medical leave of absence. **If an alternate release form is used, please do not include diagnosis or treatment information.**

SECTION I: Employee Information

Employee Name: _____

Job Title: _____

Employer Contact: Leave & Accommodations Coordinator / P 319-273-6164 / hrs-leaves@uni.edu

SECTION II: Completed by Healthcare Provider

This certification is being sought only regarding the health condition that caused the employee's need for medical leave. Based on your most recent evaluation of the employee, please identify their return-to-work status below.

☐ Employee **remains incapacitated** pending further evaluation on _____.

☐ Employee may **return to work** in the following capacity:

☐ Regular work schedule **without restrictions** starting on _____.

☐ **Modified capacity** from _____ until _____ with the following **restrictions:**

_____

and may resume working **without restrictions** on _____.

☐ **Reduced schedule:** ____ maximum hours per day ____ maximum days per week

from _____ until _____ resuming their regular work schedule on _____.

Healthcare Provider Printed Name: _____

Signature: _____ **Date:** _____

Please return this form directly to Human Resource Services via FAX at 319.273.2430