RETURN TO WORK CERTIFICATION

INSTRUCTIONS

Employees are expected to submit timely updates regarding their return to work status while on a medical leave of absence via a Return to Work Certification. If an employee remains incapacitated and is unable to return to work, the health care provider should estimate the anticipated period of incapacity and provide a prognosis of the employee’s ability to return to work based on their medical knowledge, experience, and examination of their patient. Terms such as indefinite, unknown, indeterminate etc. may not be deemed sufficient. If the employee is able to return to work in a modified duty capacity, the health care provider must identify any/all restrictions, their anticipated duration, and provide a statement regarding the prognosis of the employee’s ability to return to full duty based on their medical knowledge, experience, and examination of the employee.

Employees who remain incapacitated and are unable to return to work must submit their completed Return to Work Certification no later than one (1) business day from the date their health care provider completes the certification but no later than the end date of the latest medical certification. Employees returning to work in a modified duty capacity are encouraged to submit their completed Return to Work Certification at least two (2) business days prior to the date they anticipate returning to work; otherwise, their return may be delayed while a determination is made regarding the University’s ability to provide a modified duty assignment. Employees returning to work in a full duty capacity must submit their completed Return to Work Certification within one (1) business day from the date their health care provider completes the certification, or immediately upon their return to work; whichever occurs first. Failure to submit a completed Return to Work Certification in a timely manner may result in a denial of additional leave and/or delay in the employee’s return to work.

RETURN TO WORK STATUS - TO BE COMPLETED BY THE EMPLOYEE’S HEALTH CARE PROVIDER

I certify that I examined ________________________________ on ________________ and he/she:

Employee Name: ________________________________
Appointment date: ________________________________

☐ Remains incapacitated and unable to work pending a reevaluation scheduled for: ________________________________
Appointment date: ________________________________

Prognosis of the employee’s ability to return to work based upon your medical knowledge, experience, and examination of the patient:

________________________________________________________

☐ Is able to return to work/continue working in a modified duty capacity:

from __________ until __________

Date: __________ Date: __________

Restrictions: (Please be specific)

________________________________________________________

Prognosis of the employee’s ability to resume working in a full duty capacity based upon your medical knowledge, experience, and examination of the patient:

________________________________________________________
□ Is able to return to work on a reduced work schedule of:

__________ hour(s) per day; _________ days per week from _________ until _________

Date       Date

Employee will be reevaluated on: ____________________________

Appointment date

Prognosis of the employee’s ability to resume their standard work schedule based upon your medical knowledge, experience, and examination of the patient:

_____________________________________________________________________________

_____________________________________________________________________________

□ Is able to return to work in a full duty capacity on:

________________________

Date

Additional Information: ____________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

HEALTH CARE PROVIDER INFORMATION

Signature of Health Care Provider                        Date

Printed Name of Health Care Provider

Address

Phone                                Fax

Email completed form to: umdleave@umd.edu
OR
Fax completed form to: 301.405.5885
Attn: Leave Management Team