UNIVERSITY OF SOUTH FLORIDA

Division of Human Resources

USF Sick Leave Pool Medical Statement

Employee's Name ______________________________

I authorize the release of medical information to the University of South Florida.

Signature______________________________ Date ______________

Dear Physician:

The above referenced employee is a member of the USF Sick Leave Pool. We are willing to continue the employee's pay and benefits for a limited period of time while he/she is unable to work. USF has a return-to-work policy in place allowing the employee's duties to be temporarily changed during the recovery process in order for the employee to be returned to work as quickly as possible, provided the employee has been released by his/her physician to work light duty, reduced hours, or full duty. The physical requirements of the position are described below. Please provide us with any restrictions that should be placed on the employee should you determine that the employee can be returned to work. Also attached is a copy of the employee's position description. Please review it and determine what tasks the employee can/cannot perform and the amount of time needed during the recovery process. At the bottom of this page, temporary duties have been listed which could be assigned to the employee should you determine that the employee can return to work with restrictions. If appropriate, please provide us with any information on the reverse side of this form that will be helpful in determining if the employee can be returned to work with limited duties on a part-time or full time basis.

Physical Requirement Section: Physical Requirements and Percentage of Time are to be completed by the supervisor of the employee.

Physical Requirements	Percentage of Time	Restrictions - To Be Completed By Physician

Modified duties and physical requirements that can be temporarily assigned: ______________________________

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Supervisor's Signature ______________________________ Phone Number ______________ Date ______________

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USF Sick Leave Pool Medical Statement

Employee's Name ______________________________

Date first treated for this illness/injury: ______________________________

The restrictions indicated on the front of this medical statement are in effect from _________ to _______________

The date the employee may be returned to work with limited duties:______________________________

Please list the limitations: ______________________________

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Please provide us with any additional information that you feel may be helpful in assessing the ability of this employee to perform the physical requirements and job duties that are listed on the front of this medical statement and on the position description.

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The dates the employee is unable to work due to this illness/injury:______________________________

The date the employee may be returned to full duty: ______________________________

______________________________ ______________________________

Physician's **Original** Signature Date Signed

Physician's Information:

Name (print or type) ______________________________

Address ______________________________

City ______________________________ State ______________ Zip ______________________

License Number ______________________________ Phone ______________________________

(Request cannot be approved without Physician's license number)

Attachment (Position Description)

Revised 1/15