UNIVERSITY of SOUTH FLORIDA

CENTRAL HUMAN RESOURCES
Return to Work Form
Fax to: 813-974-5227 Att FMLA
Email: FMLA@usf.edu

Return to Work Program - Health Status Form

Part I- General Information

Employee's Name: _____ GEMS ID: _____

Doctor's Name: _____ Clinic/Facility Name: _____

Clinic's Phone Number: _____ Fax Number: _____

Part II- Completed by Employee

If an extension of leave is required, please contact **FMLA@usf.edu.** If an ADA Accommodation is needed, please contact **hr-ada-request@usf.edu**

☐ I affirm my intent to return to work on: _____. ☐ I am requesting additional leave.

_____ _____
Employee's Signature Date

Part III- Health Care Provider's Release to Return to Work – Completed by Health Care Provider

Please complete the information below. If the estimated return date exceeds the return date on the initial medical certification, an updated medical certification may be required.

☐ Employee is released to return to work at full duty, **without accommodation**, effective: _____.

☐ Employee may resume work **with the following accommodation(s)** effective: _____.

Expected duration of the accommodation is: _____.

☐ Full-time **or** ☐ Part-time – Hours per day: _____ Number of days per week: _____

Please list the employee's condition and any restrictions and job modifications the department may need to consider:

_____

_____

_____

_____

Indicate these restrictions are: ☐ Permanent ☐ Temporary Until Date: _____ (specify date, must be after employee has returned to work)

_____ _____
Heath Care Provider's Signature Date