EMPLOYEE'S RETURN TO WORK CERTIFICATION FORM

**CERTIFICATION MUST BE RETURNED TO THE COMPANY PRIOR TO ALLOWING THE EMPLOYEE TO RETURN TO WORK. FAILURE TO RETURN THE COMPLETED FORM PRIOR TO AN EMPLOYEE'S INTENDED RETURN TO WORK DATE MAY RESULT IN A DELAYED REINSTATEMENT OF THE EMPLOYEE.*

SECTION I: TO BE COMPLETED BY EMPLOYER

Employee's Name: _____

Employee's Job Title: _____ Employee's Regular Work Schedule: _____

Employer Name: **Rady Children's Hospital San Diego** Fax Number: **(858) 966.6723 (Occupational Health)**

Telephone Number: (858) 966.5865

Status: ☐ Full-Time ☐ Part-Time On leave since: _____

SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient has been on leave due to a serious health condition and/or other medical condition. Please answer, fully and completely, all applicable parts of this certification form. Your answers to the questions below should be limited to the condition for which the employee has been on leave. In other words, the certification should certify whether the employee is able to return to work and can perform the essential functions of his or her job as they relate to the employee's condition that necessitated the leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PLEASE *DO NOT* STATE OR IN ANY WAY INDICATE THE SPECIFIC NATURE OF THE HEALTH OR MEDICAL CONDITION OR DIAGNOSIS ANYWHERE ON THIS DOCUMENT WITHOUT THE PATIENT'S CONSENT.

Effective as of _____ the above named patient is hereby certified as fit to return to work duties as follows:

☐ Full-time duties, no restrictions

☐ Full-time duties, with the following restrictions (conditions and duration):

_____

_____

_____

_____

☐ Part-time duties, no restrictions

☐ Part-time duties, with the following restrictions (conditions and duration):

_____

_____

_____

_____

☐ Intermittent duties, with the following restrictions (conditions and duration):

_____

_____

_____

Additional comments, if any:

Provider's Name/Signature: _____

Provider's Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: ( ) _____ **Fax: ( )** _____

If you have any questions, please contact the Company's Human Resources Department at:

Rady Children's Hospital San Diego
3020 Children's Way, San Diego, CA 92123
Phone: Occupational Health: 858-966-5865
Fax: Occupational Health: 858-966-6723