SONOMA STATE UNIVERSITY | FACULTY AFFAIRS & SUCCESS

RETURN TO WORK CERTIFICATION

Faculty Use Only

This confidential form is to be used by Faculty who are returning from a medical LOA.

TO BE COMPLETED BY EMPLOYEE'S TREATING HEALTHCARE PROVIDER				
Sonoma State Employee Name:				
Is the employee able to perform the essential functions of his/her job?				
☐ **Yes**	Date of return to full duty:			
☐ **Yes**	With restrictions and limitations as follows: *(may include time base reduction needs)*			
Restrictions are:		Permanent		Temporary, until:
Anticipated release to full duty:				
☐ **No**	The employee is not released to return to work.			
Expected duration of continued absence:				
Note: Health care provider is not to disclose the underlying diagnosis without the consent of the patient.				
Health Care Provider Signature:				**Date:**
Health Care Provider Print Name:				

QUESTIONS/CONTACT
If you have any questions about completing this form, please call Faculty Affairs at 664-2192 (TTY dial 711)
Please return form, completed and signed, to: scott.graves@sonoma.edu, Director of Faculty Personnel