SONOMA STATE UNIVERSITY | Office of Faculty Affairs

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		
Empl 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 (CRS 877-735-2929 TTY)
Please return form, completed and signed, to: Sally Sacchetto, Director of Faculty Personnel