Instructions for Employee & Health Care Provider

Instructions for Employee

- Bring the attached Return to Work Authorization form and a copy of your job description to your health care provider
- Failure to provide complete and sufficient return to work certification may result in a delay of your ability to return from leave
- The due date for the return of completed Return to Work Authorization form is listed on the attached certification
- If you are returning to work with restrictions, it is your responsibility to notify the Disability Officer via phone: (312) 744-4969 or email: disabilityaccommodations@cityofchicago.org of the need for an accommodation
- If you are returning to work with restrictions, you may not return to work until you have completed the Reasonable Accommodation process and been approved for an accommodation by the Disability Officer

Instructions for Health Care Provider

- Answer, fully and completely, all applicable parts of the attached Return to Work Authorization form
- A medical diagnosis is **NOT** required
- Do **NOT** provide information about genetic tests, genetic services, of the manifestation of disease or disorder in the employee's family members
- Terms such as "**unknown**," "**ongoing**," and "**to be determined**" may not be sufficient to determine return to work or accommodation
- If information such as end dates are not yet determined, you may use the next follow up appointment date until it is known
- Please be sure to sign the form and provide all requested contact information

FMLA Certification for Health Care Provider

Patient Name: Patient Date of Birth:	Paperwork Due Date:

Return to Work:

Estimated Return to Work Date (with restrictions – if applicable): _____ ***(MM/DD/YYYY)***

Estimated Return to Work Date (without restrictions): _____ ***(MM/DD/YYYY)****
*A follow up appointment date may be used if date is unknown

Is the patient to remain sedentary? ☐ **YES |** ☐ **NO**

Can the patient perform the following actions while on restricted duty?
If yes, please give any weight or time restrictions. If no, please indicate.

Lifting: _____ Sitting: _____ Bending/Twisting: _____

Carrying: _____ Standing: _____ Kneeling: _____

Pushing: _____ Walking: _____ Climbing: _____

Pulling: _____ Running: _____ Crawling: _____

Driving: _____ Fine Manipulation: _____ ☐ Left Hand | ☐ Right Hand

Are there any other restrictions? ☐ **YES |** ☐ **NO**
If so, please review the employer-provided job description to answer this question. If the employer has failed to provide a list of the employee's essential functions or a job description, please answer these questions based upon the employee's own description of their job functions.

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Employee: If you are returning to work with restrictions, it is your responsibility to notify the Disability Officer via phone: (312) 744-4969 or email: disabilityaccommodations@cityofchicago.org of the need for an accommodation.

REQUIRED – Health Care Provider Contact & Signature:

Provider's Printed Name & Credentials: Provider Address:

Provider Signature: Provider Telephone #:

Date: Provider Fax #:

Type of Practice/Specialty:

Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).