FTD Leave Management
Return to Work Certification

You and your Health Care Provider must complete this form and submit it to your Human Resource Representative at least three days prior to your return-to-work.

Patient Name (Employee): _____Employee ID: _____

☐ May return-to-duty **WITHOUT** restrictions on ____ / ____ / ____
☐ Able to work **WITH** restrictions specified below from ____ / ____ / ____ through ____ / ____ / ____
☐ Has **NOT** been disabled from work while under my care or treatment

Employee can work:
☐ at least 8 hours/day
☐ no more than _____ hours/day
☐ specify any other schedule: _____

_____

Only indicate work restrictions resulting from the medical condition that caused the need for the leave of absence. In compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA), do **NOT** provide any genetic information when completing this form.

Occasionally: at least 25% but < 33% of work day; **Frequently**: >33% but < 66% of work day; **Continuously**: > 66% of work day

Employee can:	**Continuously**	**Frequently**	**Occasionally**	**Explain any accommodation or restrictions**
Stand	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Bend	_____	_____	_____	_____
Squat	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Reach	_____	_____	_____	_____
Grasp	_____	_____	_____	_____
Type/10 key	_____	_____	_____	_____
Data entry	_____	_____	_____	_____
Lift or carry:				
Up to 10 lbs	_____	_____	_____	_____
10 – 20 lbs	_____	_____	_____	_____
20 – 50 lbs	_____	_____	_____	_____
Push or pull:				
Up to 10 lbs	_____	_____	_____	_____
10 – 20 lbs	_____	_____	_____	_____
20 – 50 lbs	_____	_____	_____	_____

Can the employee safely operate equipment or machinery? ___ yes ___ no
Can the employee safely drive a motor vehicle? ___ yes ___ no
Can the employee safely work independently? ___ yes ___ no
Does employee have any environmental restrictions such as noise, extreme temperature? ___ yes ___ no
Have you prescribed medication that could impair the employee's judgment or motor coordination? ___ yes ___ no
Please explain any work restrictions or accommodations that need clarification or have not been addressed above and the duration of these restrictions/accommodations: _____

_____

Physician's Name_____ **Signature** _____ **Date**_____

Physician Address_____

I authorize and request any physician, medical practitioner, or other provider of health services who has assessed or treated my current medical condition to furnish the information requested above to my employer, FTD.

Patient/Employee Signature _____ **Date** _____

To be completed by your Employer (for internal use only):

Please advise if FTD can accommodate these restrictions? Yes_____ No_____

If "No," please advise rationale why the restrictions cannot be accommodated: _____

_____

HR Signature _____ Date _____