New York State Unified Court System

Health Care Provider Certification for Employee's Return to Work

SECTION I: To be completed by the COURT/AGENCY

Court / Agency: _____ Contact: _____

Name: _____ _____ _____
First Middle Last

Job Title: _____ Regular Work Schedule: _____

Essential Job Functions:

SECTION II: To be completed by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient is requesting approval to return to work. Before approval is granted, we must ascertain that the patient is medically cleared to return to work. Please answer the following questions based on your medical knowledge, experience, and examination of the patient.

_____ _____
Provider's name Type of practice / specialty

_____ _____ _____ _____
Street Address City State Zip

(_____) _____ (_____) _____ _____
Telephone Fax E-mail

PART A: Medical Facts

1. Approximate date condition commenced: _____ Probable duration: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

PART B: Return to Work

2. Is the employee cleared to return to work? ___No ___Yes

   If so, what is the effective date? _____

3. Is the employee unable to perform any of his/her job functions due to the condition? ___No ___Yes

   Check if Title Standard was provided: ___

   If so, identify the job functions the employee is unable to perform:

4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

Attach additional information if necessary

_____ _____

Signature of Health Care Provider Date