Clear form

Savannah State University

FMLA
Return to Work
Medical Evaluation

Date

Dear : _____

This letter is in reference to (name of employee) _____

An employee of (institution name) _____

We are investigating the eligibility of this employee to return to work following a "serious health condition, which made the employee unable to perform the functions of such employee's position."

A "serious health condition" when utilized as a basis for family leave, means an illness, injury, impairment, or physical or mental condition involving either inpatient care in a hospital, hospice, or residential health care facility, or continuing treatment by a health care provider.

The essential functions of this employee's job are as follows. Please indicate in your opinion if he/she will be able, or not, to perform these functions, and any restrictions you recommend, as of the expected return to work date of _____ .

To be completed by HR Representative	*To be completed by **health care provider. Check "Yes" or "No" next to each job task/responsibility to indicate if the employee can perform the function. Indicate restrictions in the space provided, if applicable.***	
JOB TASK/RESPONSIBILITY	☐ Yes ☐ No	**RESTRICTIONS**
JOB TASK/RESPONSIBILITY	☐ Yes ☐ No	**RESTRICTIONS**
JOB TASK/RESPONSIBILITY	☐ Yes ☐ No	**RESTRICTIONS**

Thank you for your help in this process. Should you have any questions regarding this request, please contact me directly.

_____ _____ _____

Title Phone

In your opinion, when will he/she be able to return to work and resume his/her normal duties? _____

Name of health care provider _____ Phone _____

Signature _____ Date _____

Patient/employee signature authorizing release of this information _____

Please return this completed form to the patient, in person or to the following address:

_____
Patient name

_____
Patient address

_____