

**RETURN-TO-WORK
PHYSICIAN'S CERTIFICATION FORM**

FOR _____,

(Employee Name)

**EMPLOYEE OF KENDALL COUNTY
SPECIAL EDUCATION COOPERATIVE**

Name of Physician: _____ **Phone:** _____
(Please Print)

Business Address: _____

1. Please detail the nature and status of your diagnosis of the employee as it relates to his/her job as a _____.

2. If the employee is currently absent from work or requires continued absence from work, please indicate the expected date of ability to return to work.

3. Indicate the impact of your diagnosis/medical condition, if any, on the employee's performance of his/her job duties:
 - a. while absent from work (expected date of return: _____)

 - b. upon return to employment (_____ regular work OR _____ modified work)

4. Describe whether this diagnosis/medical condition poses any limitations on the employee's ability to perform any major life activities (i.e., ability to operate a major bodily function, ability to walk, breathe, see, learn, perform manual tasks, work, and care for oneself) and, if so, to what degree.

5. In your professional opinion, is the employee **currently able** to return to work and to perform all of the essential functions of the position of _____ in the Cooperative (see **attached** materials pertaining to the functions of this position)?

6. If, in your opinion, the employee is **currently unable** to perform any one or more of the essential functions of the above position, or may pose a direct threat to health or safety to him/herself, students, or co-workers, please indicate below **any accommodations** of which you are aware that could be made by the Cooperative to enable the employee to perform those functions on either a regular or modified work schedule.

If applicable, note any restrictions in the following types of work:

- _____ **Sedentary Work** – Lifting 10 lbs. maximum and occasionally lifting and/or carrying small articles.
- _____ **Light Work** – Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.
- _____ **Medium Work** – Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects up to 25 lbs.
- _____ **Heavy Work** – Lifting 100 lbs. maximum with frequent lifting and/or carrying or objects up to 50 lbs.

7. Please provide an assessment of the degree to which corrective or mitigating measures (including prescribed medication to treat the medical condition), if any, may be used to reduce the limitations associated with the employee’s diagnosis/medical condition. Also, please describe the effect such measures may have on the employee’s ability to perform his/her job duties. *[Note: Such corrective or mitigating measures are not relevant to determine whether the individual has a “disability” but, if disabled, may be relevant when determining whether any “reasonable accommodation” is necessary.]*

8. Would the performance of the essential functions of the position of _____ by the employee create a **significant risk of substantial harm** to the health or safety of the employee, students, or co-workers? Please base your response upon the most current medical knowledge and/or the best available objective evidence about this employee. If it is your opinion that such a risk exists, please detail the specific nature and extent of the harm.

Date

Signature of Physician