Provide this form to your medical provider at each of your follow-up appointments and prior to your return to work date.

SANFORD HEALTH RETURN TO WORK MEDICAL CERTIFICATION

TO BE COMPLETED BY EMPLOYEE

Name:____ Employee #:________________________ DOB:__________

Position: ____ Department: ____

Work Phone:____________________________________ Home/Cell Phone: __________________________________

Date Leave Began: ________________________________ Estimated Return to Work Date: ______________________

Reason for Leave: □ Maternity □ Medical □ Surgical □ Work Comp □ Other ___________________________________

Employee's Signature: ____ Date: ________________________________

TO BE COMPLETED BY EMPLOYEE'S HEALTHCARE PROVIDER

To help us understand your patient's current functional status please provide the following information:

Restrictions:

During an □8 □ 10□ 12 hour workday your patient can work ________ hours/day ________hours/week.

Sit	No more than _____ hours at a time	Total _____ hours per day		
Stand	No more than _____ hours at a time.	Total _____ hours per day		
Walk	No more than _____ hours at a time.	Total _____ hours per day		
Repetitive Motion	No more than _____ hours at a time	Total _____ hours per day		
Push/Pull	□ no restriction	_____ lbs. frequently	_____ lbs. occasionally	□ never
Lift/Carry	□ no restriction	_____ lbs. frequently	_____ lbs. occasionally	□ never
Bending	□ no restriction	□ frequently	□ occasionally	□ never
Squatting	□ no restriction	□ frequently	□ occasionally	□ never
Climbing	□ no restriction	□ frequently	□ occasionally	□ never
Reaching above shoulder	□ no restriction	□ frequently	□ occasionally	□ never
Other _______________	□ no restriction	□ frequently	□ occasionally	□ never

Definition of Frequency: Occasionally = Activity or condition exists up to 1/3 of the time (0-2.5 hrs in an 8 hour work day)
Frequently = Activity or condition exists up to 2/3 of the time (2.5-5.5 hrs in a 8 hour work day)

How long will these restrictions and limitations be applicable? From ______________ (date) through______________ (date)

Are the restrictions/limitations permanent with no anticipated return to work? □ Yes □ No

If No: Estimated return to work date: ______________

What is the current course of treatment? ____

____

Return to Full Duty/No Restrictions DATE: ______________________

Physician's Signature: ____ Date: _______________

Healthcare provider's name, address & telephone number: ____

____

Submit completed form to Sanford Health Human Resources:

Email: HRLeave@sanfordhealth.org or fax (605) 312-9051 or Inter-Office Route 5204