SANTA BARBARA CITY COLLEGE
*Human Resources*
Phone: 965-0581 Fax 965-0151

# MEDICAL LEAVE WORK CERTIFICATION

**To: Santa Barbara City College Employee:**

**This form can be used for when you are taken off work due to medical reasons.**

**This form can be used when you are released to return to work. You must present the completed form to Human Resources before you return to work.**

**TO: Treating Physician or Practitioner**

Our employee (**Employee Name**), _____began a period of medical leave for his/her serious health condition on _____.
(date employee commenced leave)

As a condition of returning to work, the employee must take a physical examination and have his/her physician complete this form. This form must be completed before the employee is allowed to resume their job duties.

1. **Employee's Job Title**: _____
2. **Date of Physical Examination**: _____
3. **Date released to Return to Work**: _____
4. With respect to your understanding as to what are the employee's essential job functions, please check the source(s) where you received your information:

   _____ College job description
   _____ Discussion with the employee's supervisor
   _____ Discussion with the employee
   _____ Other – Please explain: _____

5. Please indicate the status of the employee's return to work

   _____Not released for any type of duty.

   _____ Modified duty. You must complete question #6.

   _____Fully unrestricted duty. Proceed to question #7.

6. If you are releasing the employee to modified duty, you must complete this section thoroughly.

a. Estimated date the employee will be able to return to full, unrestricted duty:_____

b. Date of your next evaluation of the employee:_____

c. Indicate the exact work restrictions which apply to the employee at this time on the chart below:

| PHYSICAL LIMITATIONS | FULL RESTRICTIONS | PARTIAL RESTRICTIONS | NO RESTRICTIONS |
|---|---|---|---|
| Sedentary-Lifting 0 to 10 pounds | | | |
| Light-Lifting 10 to 20 pounds | | | |
| Moderate-Lifting 20 to 50 pounds | | | |
| Heavy-Lifting 50 to 100 pounds | | | |
| Pulling/Pushing, Carrying | | | |
| Reaching or working above shoulder | | | |
| Walking (hrs.) | | | |
| Standing (hrs.) | | | |
| Sitting (hrs.) | | | |
| Stooping (hrs.) | | | |
| Kneeling (hrs.) | | | |
| Repeated Bending (hrs.) | | | |
| Climbing (hrs.) | | | |
| Operating a motor vehicle, crane, tractor, etc. | | | |
| Other: | | | |
| Exposure Limitation (Specify) | | | |

7. I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in_____, California this _____ day of _____ , 20__ .

| | |
|---|---|
| Signature of Treating Physician or Practitioner | Date |
| Print Name of Treating Physician or Practitioner | Phone Number |