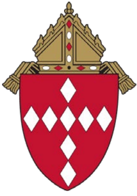

CATHOLIC DIOCESE *of* RALEIGH

Office of Human Resources

RETURN TO WORK FORM

For Use With Employees Returning From Leave Associated with FMLA or a Workers' Compensation Injury/Medical Condition, or Both

Employee Name:	**Employee SSN:**
Parish/School/Department:	**Supervisor:**
Position:	**Employee Telephone:**

Instructions:

1. **Immediate supervisor**: Give this form, along with the employee's up-to-date job description attached, to the employee. For the job description form, see: https://dioceseofraleigh.org/sites/default/files/inline-files/Position-Description-051121.pdf
2. **Employee:** Have your health care provider review your attached job description and ask them to complete this form. *Return the completed form to your supervisor upon or before your return to work.*
3. **Health care provider**: Please review the attached job description for this employee, complete this form, and return it to the patient.

Date of accident/date the medical condition began: ________________________

To the Health Care Provider:

Please check all of the option(s) that apply:

_____ • The employee is able to work a full, regular schedule with no restrictions, beginning ________________(date)

_____ • The employee is unable to return to work until _______________(date).

_____ • The employee is able to return to work on a reduced schedule for _____ hours a day from ___________(date) through________ (date).
If this option is checked, please indicate approximately when you will re-evaluate the employee to determine a return to full duty date – e.g., 30 days, 6 weeks, etc.:___________________________

_____ • The employee is able to return to work with restrictions from___________ (date) through___________(date)
Please indicate restrictions, if any, below:
Standing (number of hours): ________________________________
Walking (number of hours): _________________________________
Sitting (number of hours): __________________________________
Lifting (number of pounds): _________________________________
Carrying (number of pounds): _______________________________
Use of hands (repetitive motions, pushing, pulling): ___________________________
Other restrictions – please be specific:
____
____

_____ • The employee may return to work on ____________ (date) but has **permanent** restrictions, as follows:
____
____

By the employee's signature below, the employee acknowledges that if the Diocese requires further information regarding the employee's return-to-work status, it may contact the physician and request supplemental documentation, such as the medical note authorizing the employee's return to work.

____ ___________________________________
Employee Signature Date

Health Care Provider's signature:____ (**Note: electronic signature not acceptable)**
Printed Name:____
Telephone Number: ____
Date:____