

**CALIFORNIA LUTHERAN UNIVERSITY
MEDICAL LEAVE RETURN TO WORK CERTIFICATION**

Dear Health Care Provider:

Thank you for evaluating our employee, _____

Please review the attached job description.

1) Is the employee able to perform the essential functions of this job without restrictions? _____ Yes _____ No

2) If yes, please indicate the date this employee may return to full duties without restrictions: _____.

If, in your medical opinion, this employee is not capable of performing essential functions (attached), is the employee able to return to work with restrictions from _____ (date) through _____?

Full-time _____ Part-time _____ No _____

Please list the applicable restrictions or describe any accommodations which the department should consider.

Lifting _____	Standing _____	Balancing _____
Kneeling _____	Sitting _____	Pushing _____
Twisting _____	Stooping _____	Concentration/Attention to Detail _____
Walking _____	Reaching _____	Reaching above head/shoulders _____
Climbing _____	Crawling _____	Repetitive Motion _____
Bending _____	Crouching _____	Handling/fingering _____
Operating machinery/equipment _____		Operating computer _____
Driving a car or other vehicle _____		
Other restrictions (please specify): _____		

These restrictions are: Permanent Temporary

Anticipated date employee can return to full unrestricted duty _____

Name of Health Care Provider _____
(Please print or type)

Speciality _____

Address _____

Signature _____ **Date** _____

Completed forms should be faxed to (805) 493-3655
Or mailed to: California Lutheran University
Human Resources Department
60 West Olsen Rd.
Thousand Oaks, CA 91360