Syracuse University
Human Resources

RETURN TO WORK

Name of Employee: SUID: Home Phone:

Department: Job Title:

Today's Date: Last Day Worked:

Department Job Analysis: Brief description of job tasks to be completed by supervisor:

Chemical, Tools, Equipment, Machines Used:

Physical Demands: Based on percentage of time required during the day, please note frequency as follows:

Constant (up to 100%) **Occasional** (10% to 33%) **Never** (0%)

Frequent (34% to 67%) **Rare** (Less than 10%)

Standing		**Stooping**		**Twisting**		**Reaching Forward**	
Walking		**Kneeling**		**Climbing Stairs**		**Concentration**	
Sitting		**Crouching**		**Reaching Overhead**		**Work/Deadline Pressures**	
Pushing		**Crawling**		**Handling/Fingering**		**Typing/Keying**	
Balancing							

Lifting and Carrying: Indicate the maximum amount of weight the employee is expected to handle by placing an X in the appropriate box.	10 lbs ◯	20 lbs ◯	50 lbs ◯	75 lbs ◯	100 lbs ◯

Type of Leave:

◯ NYS Disability or Workers Compensation - Contact Risk Management at 315.443.4011 (Fax: 315.443.1154)

◯ NYS Paid Family Leave (in lieu of NYS Disability) - Contact HR Service Center at 315.443.4042 (Fax: 315.443.1063)

◯ Salary Continuation - Contact HR Service Center at 315.443.4042 (Fax: 315.443.1063)

Supervisor Name: Contact Number:

Signature_____ Date

Physician's Assessment:

I have reviewed the above employee's job requirements and my patient is:

☐ Approved to return to work on:_____(date)

☐ Approved to return to work with modifications as follows:

Duration of modifications: _____ (through date)

☐ Not approved to return to work until:_____ (targeted return to work date)

Physician's Signature_____Date:_____

NOTE: The physician's office must fax this form to the appropriate department as noted above.