SYRACUSE UNIVERSITY

RETURN TO WORK FORM

900 S. Crouse Avenue, 005 Steele Hall - 443-5367
119 Euclid Avenu Rm 107 - 443-5106

Name of Employee: _____ Today's Date:_____

Department: _____ Job Title: _____

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

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 443-4011 (Fax: 443-1154)
☐ Salary Continuation – Contact Dana Butler, Office of Equal Opportunity, Inclusion and Resolution Services at (Fax: 443-5021)

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: _____

☐ 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.