

University of Maine System

Certification of Ability to Return to Work

MEDICAL PROVIDER:

The employee named below has been absent from work on a medical leave. Please respond to the questions below to certify the employee's ability to return safely to work. Thank you.

Employee: _____

Date of anticipated return to work: _____

Essential functions of the employee's job: _____

Has the employee sufficiently recovered (from the medical condition which necessitated the leave) to perform the essential functions of the position without a substantial probability of significant risk to the employee or others? _____ Yes _____ No

If no, please specify work limitations: _____

Medical Provider's Name: _____

Signature of Medical Provider: _____

Date Signed: _____

Please return this form to:

University Approval:

Return to work on _____ is _____ approved _____ not approved.

Designated University Administrator: _____

Date Signed: _____