SANTA BARBARA CITY COLLEGE

Human Resources
Phone: 965-0581 Fax 965-0151

MEDICAL LEAVE WORK CERTIFICATION

To: Santa Barbara City College Employee:

This form can be used for when you are taken off work due to a medical reasons.

This form can be used when you are released to return to work. You must present the completed form to Human Resources before you return to work.

TO: Treating Physician or Practitioner

Our employee (**Employee Name**), _____began a period of medical leave for his/her serious health condition on _____.
(date employee commenced leave)

As a condition of returning to work, the employee must take a physical examination and have his/her physician complete this form. This form must be completed before the employee is allowed to resume their job duties.

1. **Employee's Job Title**: _____
2. **Date of Physical Examination**: _____
3. **Date released to Return to Work**: _____
4. With respect to your understanding as to what are the employee's essential job functions, please check the source(s) where you received your information:

   _____ College job description
   _____ Discussion with the employee's supervisor
   _____ Discussion with the employee
   _____ Other – Please explain: _____

5. Please indicate the status of the employee's return to work

   _____Not released for any type of duty.

   _____ Modified duty. You must complete question #6.

   _____Fully unrestricted duty. Proceed to question #7.

6. If you are releasing the employee to modified duty, you must complete this section thoroughly.

a. Estimated date the employee will be able to return to full, unrestricted duty:_____

b. Date of your next evaluation of the employee:_____

c. Indicate the exact work restrictions which apply to the employee at this time on the chart below:

PHYSICAL LIMITATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs.)			
Standing (hrs.)			
Sitting (hrs.)			
Stooping (hrs.)			
Kneeling (hrs.)			
Repeated Bending (hrs.)			
Climbing (hrs.)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify)			

7. I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in_____, California this _____ day of _____ , 20__ .

Signature of Treating Physician or Practitioner	Date
Print Name of Treating Physician or Practitioner	Phone Number