NEW YORK CITY HEALTH AND HOSPITALS CORPORATION OCCUPATIONAL HEALTH SERVICE **MEDICAL LEAVE CLEARANCE RETURN-TO-DUTY CERTIFICATION** ***(FOR NON-CENTRAL OFFICE EMPLOYEES)***	_____ Hospital or Facility _____ _____ Work Area Tel.Ext. _____ Date

Instructions:

This form is used when a non-central office employee needs to be cleared to return to work following an absence due to medical reasons. Employees whose medical leaves of absence exceed three (3) days are required to submit a "Return-to-Duty Medical Certificate" (sick note) from their personal physician or medical provider, which is subject to review by Occupational Health Services ("OHS"). The Return-to-Duty Medical Certificate must contain the following information: **1)** Diagnosis; **2)** Prognosis; **3)** the dates that the employee was unable to work due to illness; **4)** a statement that the employee may resume performance of the essential functions of his or her position, without any restrictions or modifications to that position; or **5)** In lieu of requirement 4, a statement that the employee has a disability and may only return to duty with restrictions and/or job modifications or other form of reasonable accommodation(s); **6)** the date that the employee may return to work; and **7)** the signature of the employee's physician, and the date signed, on the physician's official stationery with business address and phone number.

Note: Supervisors may **not** review an employee's medical documentation. Requests for FMLA or ADA accommodations shall be referred to Human Resources. **Affected employees may not return to duty until clearance is certified by OHS.**

HUMAN RESOURCES'/SUPERVISOR'S OHS EMPLOYEE REFERRAL	
Employee's Full Name (Print)	**Employee's Title**
Human Resources Representative (Name & Title) (Print)	**HR Rep.'s Signature**
First Day Off/Date Illness Began _____/_____/_____	**Return to Duty Date** _____/_____/_____

OCCUPATIONAL HEALTH SERVICE REVIEW	
Certification Review: Acceptable ☐ Yes	☐ No, request that employee submit additional documentation to support medical return to duty certification. ☐ No, request to return to duty is hereby submitted to Human Resources for its consideration/recommendation because disability status is asserted and reasonable accommodation is sought.
☐ Date Cleared by Medical Provider to Return to Duty _____/_____/_____ ☐ Do Not Return to Duty. ☐ Return to personal physician or medical provider for additional evaluation/treatment and submit appropriate documentation. ☐ OHS to await determination of Human Resources as to disability status and reasonable accommodation issues before any certification of the employee's medical clearance for a return to duty.	
_____ Authorized OHS Provider's Signature	_____ _____ Print Name Date

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