University of New Hampshire

Return to Work Certification
To be completed by your Health Care Provider

Patients Name _____ DOB _____/_____/_____

Date Patient can return to work _____/_____/_____

If the return to work date is unknown, provide the anticipated return to work date _____/_____/_____

The patient is able:

- ☐ to work their full schedule
- ☐ to work a reduced schedule
- ☐ to work with modification(s)

If the patient needs a reduced schedule, please provide your best estimate on the work schedule

_____ hour(s) per day; _____ days per week from: _____/_____/_____ through _____/_____/_____

If the patient needs modification, please provide the information below

Work modification(s) needed from: _____/_____/_____ through _____/_____/_____

Indicate the modification(s) below

Bend	Kneel	Squat	Climb	Stand
☐ No	☐ No	☐ No	☐ No	☐ No
☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes

Walk	Sit	Reach	Drive	Do Fine Motor
☐ No	☐ No	☐ No	☐ No	☐ No
☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes

Patient can lift/carry maximally ____ lbs

Patient can lift/carry frequently ____ lbs

What special accommodations are required?

_____

_____

Provider's Signature

Providers Name _____

Address _____

Phone _____

Signature _____

Date _____/_____/_____

Fax or mail completed form

UNH Human Resources

2 Leavitt Lane

Durham, NH 03824

Fax# 603-862-5159

10/12/2017