



SYRACUSE UNIVERSITY RETURN TO WORK FORM

Human Resources, Skytop Office Building, 443-4042

Name of Employee _____ SUID Number _____ Home Phone _____
 Department _____ Job Title _____
 Today's Date _____ 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
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Type of Leave:

- NYS Disability or Workers Compensation – Contact Risk Management at 443-5334 (Fax: 443-1154)
- Salary Continuation – Contact Dana Godbold in Human Resources at 443-5367 (Fax: 443-1063)

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.

