Loyalsock Township School District
1605 Four Mile Drive
Williamsport PA 17701
570-326-6508 fax 570-326-0770

Family and Medical Leave Return to Work Certification

A return to work medical certification will be required PRIOR to being restored to employment following a Family and Medical Leave for reason of **your own serious health condition**.

To be completed by the Employee:

Employee Name: _____ SSN: _____

Work Location: _____ Position: _____

Date Leave commenced: _____

Date of planned return to work: _____

Employee Signature: _____ Date: _____

To be completed by the Health Care Provider:

I certify that _____ is able to perform the essential functions of his/her position ***without restrictions or limitations*** effective _____.

I certify that _____ is able to perform the essential functions of his/her position ***with restrictions or limitations*** effective _____. I have completed the required Return to Work Capabilities Evaluation on page 2 of this form.

Health Care Provider's Signature _____ Date _____

Printed Name: _____

Address: _____

Telephone: _____

Please return to:

Benefits Department, District Service Center
1605 Four Mile Drive, Williamsport PA 17701
Telephone 570-326-6508, extension 1014.

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Patient _____

Next scheduled appointment _____

Physician Return to Work Authorization

The patient can return to work Full-time _____ Part-time _____

The patient is able to return to work full duty? Yes ☐ When? _____ If yes, skip to signature section.
No ☐ If no, which of the following restrictions apply?

In terms of and eight hour day, the patient can perform the listed activity for the following number of hours:		Continuously 5 – 8 hours	Frequently 3 – 5 hours	Occasionally 1 – 3 hours	Not at All
Patient may:	Sit				
	Stand				
	Walk				
Patient my lift:	0-10 lbs.				
	10-20 lbs.				
	20-50 lbs.				
	50-100 lbs.				
Patient may carry:	0-10 lbs.				
	10-25 lbs.				
	25-50 lbs.				
	>50 lbs.				
Patient may:	Push				
	Pull				
	Twist				
	Climb				
	Balance				
	Stoop				
	Kneel				
	Crawl				
	Reach				
	Grasp				
Patient may perform repetitive movement?					
Patient may drive	With clutch				
	Heavy equipment				

Are these restrictions: Temporary? Yes ☐ If yes, for how long? _____
Permanent? Yes ☐

Health Care Provider's Signature: _____ Date _____

Printed Name: _____

Address: _____

Telephone: _____ Fax: _____