PHYSICIAN RETURN-TO-WORK MENTAL HEALTH FORM

Directions: *To be completed by the employee's health care provider in anticipation of employees return to work from medical leave.*
Submit to: *Civil Service and Personnel Dept., 345 High Street, 1st Fl., Hamilton, OH 45011* **Fax:** *513-785-7037*

Employee Name:_____ Occupation/Job Title: _____
Job description attached

Employee's Date of Birth: _____ Provider's Name: _____

Next Scheduled Appointment: _____ Provider's Phone: _____

Below to be completed by Physician:

I most recently evaluated this employee on (date) _____ and certify that:

- ☐ The patient may return to work **without any limitations** on (date) _____.
- ☐ The patient may return to work **with limitations** on (date) _____.
- ☐ The patient can return to work **Part-time** _____ hours/week for _____ (duration).

If there are any limitations, ALL boxes below must be filled out.

	NO Limitations	SOME Limitations	SIGNIFICANT Limitations
1. **Understand** directives and procedures			
2. **Remember** directives and procedures			
3. **Concentrate** on tasks for extended periods			
4. **Sustain** ordinary routine without special supervision (persist at tasks)			
5. Perform activities **within a schedule.**			
6. **Maintain attendance**, and be punctual within customary tolerances			
7. **Make decisions.**			
8. **Interact appropriately** with general public, co-workers, and students (where applicable)			
9. Accept instructions and **respond appropriately** to criticism from supervisors			
10. Adhere to basic standards of neatness and cleanliness			
11. **Respond appropriately to changes** in the work setting, e.g., learn new skills and/or tasks, deviate from routine procedures, adapt to changes in the work environment, etc.			
12. Be aware of normal workplace hazards and **take appropriate precautions**			
13. Travel between work locations (where applicable).			

Please explain further any of the limitations marked above: _____
_____
_____
_____
_____

Are these limitations: ☐ Temporary ☐ Permanent If temporary, for how long? _____

Specify any environmental requirements or assistive devices, if applicable: _____
_____

_____ _____ _____
Signature of Provider Date Fax Number

_____
Address

PLEASE EMAIL/FAX THIS FORM IMMEDIATELY TO THE DEPARTMENT OF CIVIL SERVICE AND PERSONNEL:
cspersonnel@hamilton-oh.gov; Fax: 513-785-7037