



# UNIVERSITY HUMAN RESOURCES

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## RETURN TO WORK CERTIFICATION

### INSTRUCTIONS

Employees are expected to submit timely updates regarding their return to work status while on a medical leave of absence via a Return to Work Certification. If an employee remains incapacitated and is unable to return to work, the health care provider should estimate the anticipated period of incapacity and provide a prognosis of the employee's ability to return to work based on their medical knowledge, experience, and examination of their patient. Terms such as indefinite, unknown, indeterminate etc. may not be deemed sufficient. If the employee is able to return to work in a modified duty capacity, the health care provider must identify any/all restrictions, their anticipated duration, and provide a statement regarding the prognosis of the employee's ability to return to full duty based on their medical knowledge, experience, and examination of the employee.

Employees who remain incapacitated and are unable to return to work must submit their completed Return to Work Certification **no later than one (1) business day from the date their health care provider completes the certification but no later than the end date of the latest medical certification**. Employees returning to work in a modified duty capacity are encouraged to submit their completed Return to Work Certification **at least two (2) business days prior to the date they anticipate returning to work**; otherwise, their return may be delayed while a determination is made regarding the University's ability to provide a modified duty assignment. Employees returning to work in a full duty capacity must submit their completed Return to Work Certification **within one (1) business day from the date their health care provider completes the certification, or immediately upon their return to work; whichever occurs first**. Failure to submit a completed Return to Work Certification in a timely manner may result in a denial of additional leave and/or delay in the employee's return to work.

### RETURN TO WORK STATUS TO BE COMPLETED BY THE EMPLOYEE'S HEALTH CARE PROVIDER

I certify that I examined \_\_\_\_\_ on \_\_\_\_\_ and he/she:

☐ **Remains incapacitated and unable to work pending a reevaluation scheduled for:** \_\_\_\_\_  
Appointment date

Prognosis of the employee's ability to return to work based upon your medical knowledge, experience, and examination of the patient:

☐ **Is able to return to work/continue working in a modified duty capacity:** from \_\_\_\_\_ until \_\_\_\_\_  
Date Date

Restrictions: (Please be specific)

Prognosis of the employee's ability to resume working in a full duty capacity based upon your medical knowledge, experience, and examination of the patient:

☐ **Is able to return to work on a reduced work schedule of:**

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ until \_\_\_\_\_  
Date Date

Employee will be reevaluated on: \_\_\_\_\_  
Appointment date

Prognosis of the employee's ability to resume their standard work schedule based upon your medical knowledge, experience, and examination of the patient:

☐ **Is able to return to work in a full duty capacity on:** \_\_\_\_\_  
Date

Additional Information:

### HEALTH CARE PROVIDER INFORMATION

\_\_\_\_\_  
Signature of Health Care Provider Date

\_\_\_\_\_  
Printed Name of Health Care Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Fax

Email completed form to: [umdleave@umd.edu](mailto:umdleave@umd.edu)  
OR  
Fax completed form to: 301.405.5885  
Attn: Leave Management Team