Attachment A

CITY OF RED BLUFF
PHYSICIAN'S RETURN-TO-WORK CERTIFICATE

TO THE ATTENDING PHYSICIAN: Please fill in the form completely. Unless your patient brings or sends it to us before his/her anticipated date of return to work, his/her sick leave benefits and clearance to return to work may be delayed or denied. **Attached for your review is a copy of the position's classification specifications that indicate the employee's representative duties and the physical effort required to perform those duties.**

RETURN THIS FORM TO: **Scott Garrison** FAX **530-527-7036**

Name of Employee/Patient: _____ **Job Title**: _____

1. The undersigned attended to the patient for the present medical problem from _____ to_____.
2. During the time the patient was under your care, has she/he been capable of performing his/her regular work?
   Yes ☐ No ☐ If NO, disability dates: From _____ to _____
3. Prognosis: _____
4. Patient may return to FULL DUTY WITH NO RESTIRICTIONS: YES ☐ NO ☐
   If YES, effective date: _____. **If NO,** please complete "FACTORS" section below.
5. **Next appointment date:** _____

When available, the City of Red Bluff attempts to make reasonable accommodations by using short-term, modified work (limited duty) for employees who are temporarily unable to perform their full range of duties due to illness or injury. Depending upon the various activities in the employee's Department, work may possibly be found within the employee's limitations while he/she is recuperating.

Please check each box below either YES, meaning that the employee may engage in these duties, or NO, the employee is unable to perform these tasks during the normal course of recuperation:

FACTORS

VEHICLE USE	YES	NO
Car	☐	☐
Pick-up truck, van	☐	☐
Bus	☐	☐
Other	☐	☐

BODY POSITIONS		
Standing	☐	☐
Walking	☐	☐
Sitting	☐	☐
Squatting	☐	☐
Twisting	☐	☐
Reaching	☐	☐
Pushing/pulling	☐	☐
Arms above shoulder level	☐	☐
Other	☐	☐

CLIMBING	YES	NO
Stairs	☐	☐
Ladders	☐	☐
Other	☐	☐

ENVIRONMENTAL		
Temperature extreme	☐	☐
Fumes/dust	☐	☐
Chemical/biological	☐	☐
Other	☐	☐

LIFTING		
0 - 10 lbs.	☐	☐
11 - 25 lbs.	☐	☐
26 - 50 lbs.	☐	☐
51 -100 lbs.	☐	☐

SPECIAL TASKS	YES	NO
Work on elevated surface	☐	☐
Hands exposed to water	☐	☐
Work w/power equipment	☐	☐
Work alone	☐	☐
Repetitive use of wrist/elbow	☐	☐

PROTECTION REQUIRED	YES	NO
Brace	☐	☐
Splint	☐	☐
Lifting Belt	☐	☐
Other	☐	☐

5. The estimated date on which the patient may resume his/her UNRESTRICTED regular work:
   _____
6. Is the patient taking any medication that would affect job performance? Yes ☐ No ☐
7. Comments: _____

I hereby certify that the above statements, in my opinion, truly describe the patient's disability.

_____ _____ _____ _____
Signature of Attending Physician | Date | Print/Type Physician's Name | Specialty

_____ _____ _____
Address | Phone # | State License #

IF THERE ARE RESTRICTIONS, AN ACCOMODATION MEETING **MUST BE HELD BEFORE THE EMPLOYEE CAN RETURN TO WORK** TO SEE IF THE DEPARTMENT CAN ACCOMMODATE THE RESTRICTIONS. COMPLETION OF THE "Work Accommodation Request Form" IS REQUIRED