New York State Unified Court System

Health Care Provider Certification for Employee's Return to Work

SECTION I: To be completed by the COURT/AGENCY

Court / Agency: _____ Contact: _____

Name: _____ _____ _____
First Middle Last

Job Title: _____ Regular Work Schedule: _____

Essential Job Functions:

SECTION II: To be completed by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient is requesting approval to return to work. Before approval is granted, we must ascertain that the patient is medically cleared to return to work. Please answer the following questions based on your medical knowledge, experience, and examination of the patient.

_____ _____
Provider's name Type of practice / specialty

_____ _____ _____ _____
Street Address City State Zip

(____) _____ (____) _____ _____
Telephone Fax E-mail

PART A: Medical Facts

1. Approximate date condition commenced: _____ Probable duration: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

PART B: Return to Work

2. Is the employee cleared to return to work? ___No ___Yes

   If so, what is the effective date? _____

3. Is the employee unable to perform any of his/her job functions due to the condition? ___No ___Yes

   Check if Title Standard was provided: ___

   If so, identify the job functions the employee is unable to perform:

4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

Attach additional information if necessary

_____ _____

Signature of Health Care Provider Date

ESTIMATED PHYSICAL CAPABILITIES FORM

FOR NYS COURT EMPLOYEES

EMPLOYEE NAME: _____ TITLE: _____ WORK LOCATION: _____

THIS FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER:

INSTRUCTIONS: Provide medical diagnosis including a detailed description of the above-named individual's injury or illness and prognosis for recovery:

_____

_____

Please check appropriate boxes for all questions below.

1. In an eight-hour workday, how many hours can this employee:

Sit	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests
Stand	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests
Walk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously	☐ With Rests

2. In a given day, for how many total hours can this employee sit, stand, and/or walk in combination?

☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16

3. Other capabilities:

	Never	Occasionally	Frequently	Continuously
LIFT				
00-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
CARRY				
00-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
BEND				
SQUAT				
CLIMB				
RUN				
Reach above shoulder level				
Operate a motor vechicle				

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
LEFT	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Lower Extremities:

Use of feet/legs for repetitive movement, as in operation of foot controls or motor vehicles.

RIGHT	LEFT	SIMULTANEOUS
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Does this employee have any visual or hearing impairment requiring accommodation? If yes, explain. ☐ Y ☐ N

Based on your examination(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with employee returning to work? If yes, please explain. ☐ Y ☐ N

Can this employee operate moving machinery? ☐ Y ☐ N

When, in your estimation, will this employee be ready to return to work? Date: ____/____/____

HEALTH CARE PROVIDER (PRINT NAME): _____ TELEPHONE: _____

TYPE OF PRACTICE/MEDICAL SPECIALTY: _____

HEALTH CARE PROVIDER'S SIGNATURE: _____ DATE: ____/____/____