



**Medical Clearance for Return to Work**

Employee Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dear Health Care Provider,

Your patient, a Boston University employee, is seeking to return to work following a medical leave of absence. Assessment of their fitness for duty and any necessary accommodation will depend on the clear and specific medical information you provide. Please discuss with the employee their job-related duties when evaluating their ability to perform essential function **with or without accommodations**.

**I authorize my healthcare provider to release the requested information to healthcare providers at Boston University's Occupational Health Center (BUOHC).**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Care Provider: Please complete the information below and submit this and any additional clinical information requested to Confidential FAX at BUOHC: 844-537-3577**

1. Diagnosis and date of onset: \_\_\_\_\_
2. Current treatment plan and medications: \_\_\_\_\_
3. Return to work date: \_\_\_\_\_
4. Does your patient require job restrictions or accommodations to perform the essential functions of their job?  
Yes \_\_\_\_\_ No \_\_\_\_\_
5. If **Yes**, please provide specific and quantitative detail of accommodation need such as "no lifting over 10 lbs."  
\_\_\_\_\_  
\_\_\_\_\_

**Accommodation start date:** \_\_\_\_\_ **Accommodation end date:** \_\_\_\_\_

\*Accommodations exceeding 2 weeks will require additional completion of an ADA Reasonable Accommodation form which will be sent in accordance with the dates indicated above.

**I hereby acknowledge and verify by my signature that the information provided is accurate, complete, and current.**

Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Provider Name: \_\_\_\_\_ State/License # \_\_\_\_\_

Address: \_\_\_\_\_