DOMINICAN UNIVERSITY
7900 West Division Street
River Forest, IL 60305

HEALTHCARE PROVIDER RETURN TO WORK CERTIFICATION

Employee Name: _____
(please print)

Date of release to return to work: _____

Statement of Healthcare Provider:

I certify that the above named person has been under my care. He or she has described the physical and mental requirements of the position the person holds at Dominican University. I release this person to return to work with the following accommodations/restrictions:

- ☐ No restrictions or accommodations
- ☐ The following restrictions/accommodations are required (Please describe the restriction(s) or accommodation(s) and the anticipated date when the employee will be at full capacity)

_____
_____
_____
_____
_____
_____
_____

Healthcare Provider Name (please print): _____

Healthcare Provider Area of Specialty (please print):_____

Healthcare Provider Signature: _____

Date: _____

HR USE ONLY

Payroll (circle one): FACULTY STAFF

☐ Sick / Vacation entered into Paycor Time & Attendance - _____ (HR rep)

☐ Entered into Comings & Goings - _____ (HR rep)