

_____ School District
RETURN TO WORK EVALUATION FORM

Employee Name: _____ Work Location: _____

Date of Injury/Illness: _____ Reason for Leave: _____

Part I: To be completed by the Supervisor or Principal
(Please attach a current job description or provide a description of job duties.)

In an 8-hour or _____ workday (adjust based on contractual hours), which of the following activities listed below are functions of the job and how many consecutive hours are spent doing these activities?

Activity	Consecutive Hours				Activity	Consecutive Hours				Activity	Consecutive Hours			
	6-8	4-5	1-3	0		6-8	4-5	1-3	0		6-8	4-5	1-3	0
Sitting					Grasping					Teaching/Training/ Learning Skills				
Standing					Hearing					Speaking/Lecturing/Oral Presentation Skills				
Walking					Distance Vision					Creative Thinking				
Pushing					Peripheral Vision					Decision Making				
Pulling					Close Vision					Adapt to Frequent Changes				
Twisting					Work at Heights					Problem Solving				
Climbing					Work Outdoors					Collaboration/ Interpersonal Skills				
Balancing					Work Indoors					Conflict Resolution				
Bending					Work in Temperature Extremes					Associate and Work with Various Age Groups				
Crawling					Work in Stressful Environment					Other (<i>list</i>):				
Kneeling					Manual Dexterity									
Reaching					Repetitive Hand/ Wrist Motion									

In an 8-hour or _____ workday (adjust based on contractual hours) workday, how much weight and how frequent are the lifting requirements?

Weight <i>Number of pounds required for lifting and carrying per workday.</i>	Handling/ Frequency <i>Number of times per workday that requires a person to lift and carry weight.</i>			
	15 +	10-15	1-10	0
Less than 10 pounds				
10-50 pounds				
50-100 pounds				
Over 100 pounds				

Is/Are other temporary work/assignments available in the department? Yes No

Comments regarding job duties: _____

Supervisor/
Principal Name: _____ Title: _____

Signature: _____ Date: _____

Part II: To be completed by the Patient/Employee
(Please read the following and sign where indicated. Take this form to your Healthcare Professional to complete Part III and return it to Human Resources.)

I authorize my healthcare professional to release information to my employer, _____ School District, and Lamoille North Supervisory Union about my health condition(s) as it pertains to my work.

Employee Signature: _____ Date: _____

Part III: To be completed by a Healthcare Professional

To enable the employee to return to work, please complete the following section, sign and return the form to: Human Resources Department, Lamoille North Supervisory Union, 95 Cricket Hill Road, Hyde Park, Vermont 05655. You may retain a copy for your files. The position description and the principal/supervisor's evaluation of the position are attached to provide you with an assessment of what the employee is expected to perform. Please consider these in responding to this form. If the principal/supervisor indicated that the activity was not performed (as indicated by "0" hours a day) there is no need to respond to that particular activity.

If the patient/employee is totally unable to perform work at this time, please estimate the period of disability: _____

Is the patient/employee able to perform the duties without limitation as outlined in the attached job description? Yes No

If you recommend any accommodations, please describe limitations on the employee's duties and suggest accommodations:

Considering the essential functions of the employee/patient's position and principal/supervisor's evaluation, will the patient/employee pose a direct threat, (i.e.: a significant risk of substantial harm) to the health and/or safety of :

Him/Herself? Yes No Or to others? Yes No

If yes, what are the accommodations that would eliminate risk or reduce the risk to an acceptable limit?

In an 8-hour workday, how many consecutive hours may this person spend doing the following activities?

<u>Activity</u>	<u>Consecutive Hours</u>				<u>Activity</u>	<u>Consecutive Hours</u>				<u>Activity</u>	<u>Consecutive Hours</u>			
	6-8	4-5	1-3	0		6-8	4-5	1-3	0		6-8	4-5	1-3	0
Sitting					Grasping					Teaching/Training/ Learning Skills				
Standing					Hearing					Speaking/Lecturing/Oral Presentation Skills				
Walking					Distance Vision					Creative Thinking				
Pushing					Peripheral Vision					Decision Making				
Pulling					Close Vision					Adapt to Frequent Changes				
Twisting					Work at Heights					Problem Solving				
Climbing					Work Outdoors					Collaboration/ Interpersonal Skills				
Balancing					Work Indoors					Conflict Resolution				
Bending					Work in Temperature Extremes					Associate and Work with Various Age Groups				
Crawling					Work in Stressful Environment					Other (/list):				
Kneeling					Manual Dexterity									
Reaching					Repetitive Hand/ Wrist Motion									

In an 8- hour or _____workday (adjust based on contractual hours), how much weight and how frequently may the patient/employee lift?

Weight <i>Number of pounds required for lifting and carrying per workday.</i>	Handling/ Frequency <i>Number of times per workday that requires a person to lift and carry weight.</i>			
	15 +	10-15	1-10	0
Less than 10 pounds				
10-50 pounds				
50-100 pounds				
Over 100 pounds				

Healthcare Professional Signature: _____ Date: _____

9/09

<p><u>FMLA LEAVE OR LOA FORM</u></p> <p>RETURN TO WORK CONFIRMATION</p> <p>-----</p> <p>Administrator/Supervisor: Complete, sign and send to Central Office for every employee returning from FMLA or LOA</p> <p>-----</p> <p>Name: _____</p> <p>School: _____</p> <p>LOA: Return to Work Date: _____</p> <p>Administrator/Supervisor: _____ Date: _____</p>
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Lamoille North Supervisory Union

INSTRUCTIONS FOR COMPLETING THE RETURN TO WORK FORM

Overview of FMLA

In keeping with state and federal Family Leave Act requirements, it is necessary to inform employees at the time they go out on a medical leave that it will be time covered under the Family Leave Act and will run concurrently with any contractual or stated leave benefit (paid or otherwise) provided.

The total amount of time allowable under FMLA is 12 weeks in a 12-month period. The federal law allows for up to 12 weeks of this time to be paid if the employee chooses and if a paid benefit is available. Under Vermont law, six weeks of the 12-week period may be used in combination with a paid benefit, if the employee so chooses.

Also under the FMLA, employees must be notified at the commencement of their leave that a "fit for duty" form, such as the attached form will be required in order to return to work.

Supervisor/Principal's Instructions for completing this Return to Work Form

1. Supervisors/Principals should ensure that a current job description is written and on file with the Human Resources Department. If there is no job description or it is not current, please contact the HR/Business Manager for assistance in drafting one.
2. Review the current job description and the ADA approved essential requirements to perform the job. Using this information complete Part 1 of the form.
3. Part 1 requires you, as the direct supervisor to make an educated judgment on the kinds of activities and the duration of the activity during the usual 8-hour work day. The second table asks you to decide, again based on the job description, the amount of lifting required.
4. If there is other temporary work or alternative assignments available in your department please check the appropriate box. Please feel free to contact Human Resources/Business Manager if you have a question about this.
5. If there are unique duties/tasks, schedules or issues around the employee's job, please state this under the comment area.
6. Sign the form and return with the current job description to Human Resources. If at any time you have questions, please contact Human Resources.

Employee's Instructions for completing this Return to Work Form

1. In order to ensure your timely return to work and/or to identify any necessary accommodations you may require, this form must be completed and returned to Human Resources prior to your date of return to work.
2. You will need to sign under Part II to release information about your health condition as it relates to your work.
3. After Part I and Part II has been completed, you will need to share this form with your health care professional for their completion of Part III. In order for your healthcare professional to have a clearer idea of the requirements of your job, please make sure that a current job description is attached.
4. Once the form has been completed, please return this to the Human Resources Department. Please contact your supervisor or Human Resources at any point if you have questions about this form.

Healthcare Provider's Instructions for completing this Return to Work Form

1. To enable the employee to return to work as quickly as possible, please review Part I of the form and review the essential functions of the job description.
2. If the employee is unable to return to work or unable to perform the essential functions of the job as listed, please complete the first few questions and return to the Lamoille North Supervisory Union Human Resources Department, 95 Cricket Hill Road, Hyde Park, Vermont 05655 or return to the employee/patient.
3. If the employee is able to return to work or is able to perform some of the essential functions of the job as listed, please complete the tables and return to the employee/patient or the Lamoille North Supervisory Union Human Resources Department, 95 Cricket Hill Road, Hyde Park, Vermont 05655.
4. Please affix your signature prior to returning the form. You may keep a copy for your records. Should you have questions, please feel free to contact the employee's supervisor or the Human Resources/Business Manager at 851-1160.