GEORGIA STATE UNIVERSITY
Worker's Compensation Return to Work Medical Certification

To be completed by **GSU BENEFITS**

Employee Name:	**D.O.B.**
Job Title:	**Department:**
Job Description: *See Attached*	
Essential Functions of Employee's Job: *See Attached*	

To Be Completed by the **HEALTHCARE PROVIDER**

INSTRUCTIONS: Please review the Essential Functions (listed above) and Job Description (attached) and then complete and sign this form.

Treating Physician Name:	**Specialization/Type of Practice:**	
Address:	**Tel. No.:**	**Fax No.:**

Questions for Treating Physician:

1. What is the employee's workplace injury or illness?

_____

_____

2. What are the employee's return-to-work restrictions?

_____

_____

3. Based on your review of the employee's job description, what job tasks is the employee unable to perform with the return-to-work restrictions?

_____

_____

_____

4. Are the employee's return-to-work restrictions permanent? Yes No

5. When will the employee be able to return to the essential functions of the employee's regular duties?
(Re-Evaluation Dates NOT accepted in lieu of providing requested information).

_____

_____

Signature of Treating Physician (*stamps & designee signatures **NOT** accepted)*:	**Date:**

RETURN FORM TO:

Benefits Office
Georgia State University
P. O. Box 3982
Atlanta, GA 30302-3982
Tel: 404-413-3330 / Fax: 404-413-3324