AEROSPACE

Return to Work Certification

CERTIFICATION MUST BE FAXED TO EMPLOYEE BENEFITS AT LEAST 2 WORKDAYS PRIOR TO THE EMPLOYEE'S RETURN TO WORK. FAILURE TO RETURN THE COMPLETED FORM 2 WORKDAYS PRIOR TO AN EMPLOYEE'S INTENDED RETURN TO WORK DATE MAY RESULT IN A DELAYED REINSTATEMENT OF THE EMPLOYEE. THE FAX NUMBER IS 310-563-7930.

Employer Name: **The Aerospace Corporation** **Employee Benefits Service Center** Phone: 310-336-2400

SECTION I: TO BE COMPLETED BY EMPLOYEE

Employee's Job Title:

Employee's Regular Work Schedule (e.g. 30 hrs. per week):

Please complete Section I before giving this form to your medical provider. Applicable law permits your employer to require that you submit a timely, complete, and sufficient return to work certification to verify your ability to return to work and to safely perform the essential functions of your job as those essential functions related to your medical condition. This certification is requested by the Corporation in order for you to return to work. **Failure to provide a complete and sufficient return to work certification may result in a delay of your reinstatement.**

Employee Name: _____
First Middle Last

Employee No: _____ Extension: _____ Mail Station: _____

Supervisor's Name: _____ Extension: _____ Mail Station: _____

_____ _____
Employee Signature Date

Status: Full-Time ☐ Part-Time ☐ On leave since: _____

SECTION II: TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient has been on leave due to a serious health condition and/or other medical condition. Please answer, fully and completely, all applicable parts of this certification form. Your answers to the questions below should be limited to the condition for which the employee has been on leave. In other words, the certification should certify whether the employee is able to return to work and can perform the essential functions of his or her job as they relate to the employee's condition that necessitated the leave. A Job Description, which contains a list of the patient's essential job functions, is attached.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PLEASE *DO NOT* STATE OR IN ANY WAY INDICATE THE SPECIFIC NATURE OF THE HEALTH OR MEDICAL CONDITION ANYWHERE ON THIS DOCUMENT WITHOUT THE PATIENT'S CONSENT.

FAX Form To: 310-563-7930

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Return to Work Certification

Name: Employee No.: Date:

The above named patient is hereby certified to return to work on _____ and is fit to work duties as follows:

☐ Full-time duties, no restrictions

☐ Full-time duties, with the following restrictions **(conditions and duration)**:

_____

_____

_____

_____

☐ Part-time duties, no restrictions **(No less than 20 hours)**

☐ Part-time duties, with the following restrictions **(conditions and duration)**:

_____

_____

_____

_____

☐ Intermittent duties, with the following restrictions **(conditions and duration)**:

_____

_____

_____

_____

☐ If the employee returns to work in the position for which the Job Description is attached, there is risk of harm to the employee in attending or performing the job.

☐ If the employee returns to work in the position for which the Job Description is attached, there is risk of harm to the employee's co-workers if the employee attends or performs the job.

If such a risk exists, please describe in as much detail as possible what risk(s) exist.

_____

_____

_____

_____

_____

_____

_____

_____

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Name: Employee No.: Date:

If such a risk exists, what accommodations, if any, would help minimize any such risk(s), and to what degree? Please describe in as much detail as possible.

Additional comments, if any:

Provider's Signature: Date:

Provider's Name:

Provider's Business Address:

Provider's License Number:

Type of Practice/Medical Specialty:

Telephone: Fax:

If you have any questions, please contact The Employee Benefits Service Center at 310-336-2400.

The Aerospace Corporation
Employee Benefits Department – M1/433
P. O. Box 92957-2957
Los Angeles, CA 90009
FAX: 310-563-7930

FAX Form To: 310-563-7930