



Section: 300 – Personnel

Subject: Return To Work Clearance

I. Purpose

The purpose of this policy is to assess employees returning from a medical leave of absence for their ability to perform their essential job functions, to ensure that they are not a health or safety risk to coworkers, the public or patients, and to execute this in a manner consistent with State and Federal law, including the Americans with Disabilities Act.

II. Procedure

A. Policy Provisions

1. Jackson Health System (JHS) is committed to providing a safe and healthy workforce. To that end JHS utilizes Employee Health Services (EHS)
2. It is the policy of JHS to require a Return to Work (RTW) clearance for employees who have been absent from work due to injury or illness and meet one of more of the following conditions:
 - a. Have an absence of four (4) or more consecutive calendar days for a work-related illness or injury;
 - b. Are unable to return to full duty;
 - c. Have been absent with a contagious disease as outlined in Infection Control Manual Policy #355 Infectious and Communicable Diseases;
 - d. Have an extended absence for non-work related medical reasons.
3. The Employee Health Services Return to Work evaluation must be obtained prior to the employee returning to their work assignment. Every employee of the Jackson Health System is expected to report to work on time and is responsible to obtain the EHS clearance in a timely manner and before they are scheduled to return to work.
4. The specific nature of an employee's personal health problem(s) will remain confidential and may only be released to the supervisor with the employee's written consent.
5. Employee Health Services will provide work status information to management, however, consisting of whether or not an employee has been cleared to return to work, or whether or not any further referrals/restrictions will be necessary.

B. General Guidelines:

1. Employees who use a leave of absence for health reasons (or for any circumstances listed below) are required to submit a physician's statement prior to being allowed to resume work.
2. Employees who do not provide appropriate certification will not be allowed to resume work until the documentation requested is produced and clarified by EHS. Moreover, employees who call in alleging an illness and subsequently fail to provide medical documentation may be subject to disciplinary action.



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3. Employees must provide a detailed physician's statement by using either JHS Physician's Evaluation Form (see Appendix A - Healthcare Provider Evaluation Form and Return to Work Clearance), or provide a detailed statement on physicians' office letterhead which includes the following information:
 - a. Diagnosis
 - b. Return to work Status e.g. Full duty, restricted duty. If extension of leave, estimated date of return to full work status.
 - c. If placed on restricted duty, restrictions must be specific and include the duration of the restrictions
 - d. The note must have providers printed name, signed and dated

If the physician's note is incomplete, the employee will not be cleared which can result in delay in returning to work as scheduled.

Employees with open/draining wounds will not be cleared to return to work until resolved.

4. Depending on the type of absence, the employee may or may not be required to visit the EHS clinic for clearance. Here are the general guidelines:
 - a. EHS clinic evaluation required:
 - i. After any injury or illness for 4 (four) days or longer;
 - ii. After absence due to a work related injury;
 - iii. Leave of Absence (LOA) due to medical reasons;
 - iv. Hospitalization
 - v. After any type of infectious respiratory illness (i.e. bronchitis and pneumonia)
 - vi. Following a Reasonable Accommodation request or any modification of job assignment (i.e. restricted duty) as a result of a medical condition;
 - vii. Following the Last Chance Agreement counseling or Disciplinary action counseling that requires medical monitoring;
 - b. Physician's clearance only - without EHS evaluation:

Employees have an option to submit these clearances to the EHS via email or in person

 - i. Following an absence due Cold/Flu;
 - ii. Absence due to pink eye;
 - iii. Any other absence due to non-surgical, non-infectious condition;
 - iv. Strep throat infection (requires notation of 7-10 day course antibiotic treatment on MD note has passed 24 hour period; otherwise clinic visit is required)
 - c. Return to work clearance not required for:
 - i. Funeral leave
 - ii. Vacation
 - iii. Paternity leave
 - iv. FMLA for baby-bonding
 - v. FMLA for care of family member (non- infectious)
 - vi. Maternity leave (non-c/section)
5. Employees should call the Employee Health Services at 305-585-6903 or email to JHS-ReturnToWork@jhs-miami.org if they have any questions or concerns regarding the Return to Work clearance process.



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III. References

JHS Policy No. 319 - Personal Leave, Leave of Absence, Mandatory Leave, Union Leave
 JHS Policy No. 324 - Illness on Duty
 JHS Policy No. 347 - Injury and Illness Reporting Worker's Compensation
 JHS Policy No. 355 - Infectious and Communicable Diseases, Prevention and Management of Exposures
 JHS Policy No. 358 - Absenteeism

Responsible Party:

Senior Director, Total Rewards & EWellness
 Jackson Health System

SVP and Chief Human Resource Officer
 Jackson Health System

Reviewing Committee(s): Not Applicable**Authorization:** President and CEO, Jackson Health System



Employee Health Services

Jackson Medical Towers, 11th Floor, Suite 1129

305-585-6903

JHS-ReturnToWork@jhs-miami.org

Healthcare Provider Evaluation Form Return to Work Clearance

HEALTH CARE PROVIDER MUST PROVIDE RETURN TO WORK CERTIFICATION BY COMPLETING THIS FORM

Employee's Name: _____ Phone Number: _____ DOB: _____

Date medically clear to return to work: ___/___/___

Diagnosis or description of injury/surgery/illness: _____

Patient's return to work status:

Return to full duty Date: ___/___/___

Return to work with noted restrictions From Date: ___/___/___ To Date: ___/___/___

Detailed Restrictions: _____

***If Restrictions, employee must be seen at the clinic**

Health Care Provider's Signature _____

Print Name _____

Phone Number: _____ Date _____

Address City and State Zip: _____

MD Office Stamp

EMPLOYEE HEALTH SERVICES USE ONLY

EHS Review Type: **Clinic Visit** **Email:**

Time Arrived: _____ Time with Provider: _____ Time Discharged: _____

Status Dates: Return to full duty on: _____ R.A.C Referral: _____

Discharge Instructions/Restrictions: _____

Cleared to Return to Work: YES NO Need to Follow-Up with EHS

Nurse Examiner Name/Signature: _____ Date: _____

Employee must complete:

I UNDERSTAND THE ABOVE INSTRUCTIONS AND MY RESPONSIBILITY FOR FULL COMPLIANCE:

EMPLOYEE SIGNATURE: _____ Date: _____

Supervisor Name: _____

Supervisor Phone: _____ Email: _____