SAINT JOSEPH'S UNIVERSITY

COVID-19 Returning to Campus (Faculty and Staff Form)
Fitness for Duty Certification

This form should be completed by members of the faculty and staff who have exhibited symptoms of coronavirus/COVID-19, have been diagnosed with coronavirus/COVID-19, are returning from a CDC Level 2 or 3 Travel Alert location, or were exposed to coronavirus/COVID-19.

When your physician releases you from care, you will be required to present this certificate directly to the Office of Human Resources 1-2 business days prior to your planned return to work date. Failure to submit this form may delay your return to work.

SECTION 1 to be completed by Employee:

Name: _____ Department: _____

Date Leave Began: _____ Date of Planned Return: _____

I understand that my restoration to employment is subject to the following conditions:

- As a condition of restoration, each employee taking a leave of absence for cautionary self-isolation due to suspected exposure to COVID -19 ; travel to Level 2 or 3 countries; or for his or her own serious health condition such as COVID-19 must provide a written certification from his or her healthcare provider stating that the employee is able to resume working. (see below)
- Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

_____ _____
Employee's Signature Date

SECTION 2 to be completed by Physician if employee is returning from leave for his/her own serious health condition,

I have examined _____ and have reviewed the position description for the job that this employee performs for Saint Joseph's University. I certify that this employee is fit to resume the essential functions of her/his position with the University as follows:

_____ Fully with no restrictions as of _____.
(Date)

_____ With restrictions as noted below as of _____.
(Date)

Restrictions: _____

_____

_____ Restrictions must be in place until _____.
(Date)

_____ _____
Health Care Provider's Signature Date

_____ _____
Health Care Provider Name (printed) Health Care Provider Address/Phone

Office of Human Resources
215 West City Avenue
FAX 610-660-1370