STAFFORD TOWNSHIP SCHOOL DISTRICT

Return to Work Certification Form

For Staff Members with Suspected or Confirmed

COVID-19 Related Illnesses

In accordance with state and local laws and regulations, the district will notify local health officials, staff, and families immediately of any case of COVID-19 while maintaining confidentiality in accordance with the Americans with Disabilities Act (ADA). Staff members who have had close contact with a person diagnosed with COVID-19 are advised to stay home and self-monitor for symptoms, and follow the current guidance as communicated by the Centers for Disease Control and Prevention (CDC) guidance if symptoms develop.

This form is to be completed by a certified health care provider and is intended for return to work purposes after a medical leave of absence due to a COVID-19 related illness or quarantine experience. An employee who has taken such a medical leave must present this form to Human Resources prior to returning to work.

For Health Care Professionals:

All healthcare providers must adhere to the current CDC guidelines regarding an employee's safe return to work, keeping in mind that the patient works in a large public school district.

Below is a link to the CDC webpage for Discontinuation of Isolation

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

This patient has three return-to-work options:

- **Full Release**. The patient has no work restrictions. They can return to their prior position because you, the health care provider, certify that they can perform the essential functions of their job as per CDC guidelines.
- **Modified Duty**. The patient has some work restrictions. Work restrictions must be specifically notated in the specified area on this form. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job as per CDC guidelines and return to work.
- **Not Released**. The patient is not released to work in any capacity as per CDC guidelines and due to COVID-19 related limitations.

GINA Provision

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.

Submission

The Return to Work certification (see next page) must be submitted to:

Barbara D'Apuzzo, Director of Personnel

250 North Main Street
Manahawkin, NJ 08050

Email: bdapuzzo@staffordschools.org

Phone: 609-978-5700 x1400

Fax: 609-597-4335

STAFFORD TOWNSHIP SCHOOL DISTRICT

Return to Work CERTIFICATION

for Staff Members

with Suspected or Confirmed COVID-19 Diagnosis (to

be completed by the staff member's physician)

Employee/Patient Name (Last, First, & Middle)	**Date of Exam**
Employee's Release for Duty Status	
☐ Full, unrestricted duty effective___/___/_____ ☐ Modified duty effective____/____/_____and next evaluation date____/____/_____ ☐ Not released for any type of duty. Next evaluation date will be___/___/_____ Link to the CDC webpage for Discontinuation of Isolation : https://www.cdc.gov/coronavirus/2019- ncov/hcp/disposition-in-home-patients.html	
Return to Work Practices and Work Restrictions (as per current guidelines established by the Centers for Disease Control and Prevention (CDC).	

I hereby certify that the facts in this document are true and correct.

Health Care Provider

Signature:_____

Name (print):_____**Date:**_____

Phone Number:_____