Medical Separation Review

Employee name _____Phone _____

Payroll title _____

Department _____

Department head _____Phone _____

1. What are the medical reasons for separation?

2. What essential functions of the job can the employee no longer perform with or without accommodation? (Give brief description and attach position description.)

3. Summarize briefly, all reasonable accommodations or job modifications considered or implemented. Include any reasonable accommodations that were attempted and failed (Attach all appropriate documentation, as applicable.)

4. Summarize Interactive Process between employee and department (attach written documentation).

5. Has a Workers' Compensation (WC) claim been filed? ☐ Yes ☐ No
   Have you notified the Workers' Compensation unit of the intent to medically separate the employee?
   ☐ Yes ☐ No

6. Has the employee used all leave entitlements? ☐ Yes ☐ No
   List end dates for those applicable to this employee:
   a. Sick leave end date: _____
   b. Family & Medical Leave end date: _____
   c. (PPSM only) Supplemental Family & Medical Leave end date: _____
   d. (WC only) Extended sick leave (supplemental benefits) end date: _____

Approval of Medical Separation:

Department head_____Date _____

c: Department
Disability Management Services (campus)/Vocational Rehabilitation (UCDHS)
Workers Compensation (if claim was filed)

Official Use Only

Comments by Vocational Rehabilitation Counselor:

Approved by:
Voc Rehab Counselor _____Date _____

Print Form