

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 \_\_\_\_\_

cc: 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 \_\_\_\_\_