

Notice of Intention to Return from FMLA Leave

Employee Instructions

1. Complete the top portion of this form and sign it.
2. Give the form to your health care provider and ask him / her to complete the bottom portion.
3. Return the completed form to Human Resources before your return to work date.

Name: _____

Job Title: _____

Supervisor: _____

Date leave commenced: _____

Date of planned return: _____

I understand that my restoration to employment upon the exhaustion of FMLA leave is subject to the following conditions:

- As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working.
- Every attempt will be made to restore an employee returning from FMLA 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.
- An employee returning from family and medical leave shall not be entitled to the accrual of any seniority or employment benefits during the period of leave.

Employee Signature

Date

Health Care Provider Instructions

This form is required for the above employee to return to work after a leave of absence. Please complete this form and sign below.

Name: _____

Address: _____

Telephone number: _____

I certify that on _____, the above named employee is or will be able to resume performing the functions of his / her position without restrictions, as set forth on the attached job description.

I certify that on _____, the above named employee is or will be able to resume performing the functions of his / her position, but with some restrictions. Those restrictions are:

I certify that the above named employee cannot perform the following job functions:

Physician's Signature

Date

Physician's Printed Name