FAMILY AND MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

EMPLOYEE: PLEASE COMPLETE TOP PORTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Employee:

Employee's Department:

Department Contact:

Telephone Number:

HEALTH CARE PROVIDER: PLEASE COMPLETE AND RETURN DIRECTLY TO DEPARTMENT PRIOR TO RETURN TO WORK DATE.

Please review the attached job description. Is the employee able to perform all the functions of his or her job?

☐ Yes ☐ No ☐ Yes, with restrictions or accommodations.

When did the serious health condition begin?

Please list any restrictions or describe accommodations which the department should consider:

Are the restrictions: ☐ Permanent ☐ Temporary, until (date):
If so, please describe the recommended schedule.

Comments:

Employee is released to return to work effective (date):

Name of Health Care Provider:

Specialty:

Address:

Place address stamp here.

_____ _____
Signature of Health Care Provider Date

RETAIN: 3 YEARS

01/00