OZARK R-VI SCHOOL DISTRICT
FAMILY AND MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

EMPLOYEE: PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER. THIS CERTIFICATION MUST BE PROVIDED TO YOUR DEPARTMENT PRIOR TO YOUR RETURN TO WORK.

Employee:
Employee's Department:
Department Address:
Department Contact:
Telephone Number

HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE DEPARTMENT LISTED ABOVE PRIOR TO THE 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.
Please list any restrictions or functional limitations which the department should consider:
Are the restrictions: □ Permanent □ Temporary, until (date):
Comments
Employee is released to return to work effective (date):
Name of Health Care Provider:
Specialty:
Address of Health Care Provider

Signature of Health Care Provider	Place address stamp here Date

COPY TO: DEPARTMENT FILE
PAYROLL OFFICE

RETAIN: 3 YEARS