Ozark 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:* _____

*Place address stamp here*

*Signature of Health Care Provider* _____ *Date* _____

***Please return to Benefits Specialist Morgan Hall | Fax: 417-582-5950***