Certification of Work Ability Form

School District of Ashland

SCHOOL DISTRICT OF ASHLAND
EXCELLENCE IN EDUCATION

Employees, complete section one; then ask your medical provider to complete section two. If an employee's FMLA Leave was due to their own serious injury or illness, this form must be submitted to the Human Resources Department before they can return to work.

*A medical providers work ability certification form can be substituted for this form.

Section One: To be completed by the **Employee**

Employee Name: _____ Building: _____

I am acknowledging that I am prepared to return to work from my FMLA leave on _____.

Signature: _____

Section Two: To be completed by the **Medical Provider**

My signature below certifies that the employee named in section one may return to work on this date _____.

The employee will be returning with restrictions: ☐ No ☐ Yes

If yes, please describe the restrictions: _____

_____

If yes, estimated length of time that the employee will have restrictions: _____

Signature of Medical Provider: _____ Date: _____

Printed Name of Medical Provider: _____

Section Three: To be completed by the **Human Resources Department**

☐ Notify Supervisor of Restrictions
☐ Notify Supervisor of Date of Return
☐ Follow-up with Employee until restrictions are lifted

Human Resources Signature: _____ Date: _____