Return to Work Medical Certification

FMLA Leave

PART 1: TO BE COMPLETED BY EMPLOYEE (please print or type)

Employee Name: _____ Date Leave Began: _____
(First Name, Middle Initial, Last Name)

Employee Position: _____

Employee Signature: _____ Date: _____

PART 2: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

I certify that on _____, _____ , is able to resume
(Date) (Name of Employee)

performing the functions of his/her position with or without reasonable accommodation.

Healthcare Provider Signature: _____ Date: _____