UNIVERSITY of WISCONSIN
GREEN BAY

FAMILY CARE & MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

Instructions: *Please print. Complete and mail to the attention of Human Resources prior to return to work date.*

IDENTIFICATION: EMPLOYEE TO COMPLETE THIS SECTION
Employee's Name:
Name of Supervisor:
Department/Address:

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION	
Please review the attached job description. Is the employee able to perform all the essential functions of this job? ☐ Yes ☐ No	
If yes, please list any restrictions or describe accommodations that the department should consider.	
The restrictions are: ☐ Permanent ☐ Temporary, until: _____ (specify date)	
Comments:	
Date employee is released to return to work:	
Name of Health Care Provider:	
Specialty:	
Phone:	
Address:	
Signature:	Date:

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