**family care and medical leave return to work certification**

**Instructions:**

Please Print.

Please complete and mail to the attention of Human Resource prior to return to work date.

|  |  |
| --- | --- |
| **Identification: Employee to complete this section** | |
| Employee 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 restriciton or describe accommodations that the department should consider: | | | | | |
| The restrictions are: | | Permanent  Temporary, until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(specify date)* | | | |
| Comments: | | | | | |
| Date employee is release to return to work: | | | |  | |
| Name of Health Care Provider: | | |  | | |
| Specialty: |  | | | | |
| Phone: |  | | | | |
| Address: |  | | | | |
| Signature: |  | | | | |
| Date: |  | | | | |