**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.

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| **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: |  |