

# RETURN TO WORK CERTIFICATION For Family and Medical Leave (FML)

## SECTION I – To be completed by THE UNIVERSITY

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

EMPLOYEE'S DEPARTMENT

DEPARTMENT CONTACT

DEPARTMENT CONTACT'S MAILING ADDRESS

PHONE

(     )

FAX

(     )

E-MAIL

## SECTION II – To be completed by HEALTH CARE PROVIDER

**PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR TO THE DEPARTMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE**

Important: Please limit your answers below to the serious health condition for which the employee has been on leave.

NAME OF HEALTH CARE PROVIDER

PLACE ADDRESS STAMP HERE:

ADDRESS

1. Is the employee now able to perform those essential functions of his or her job that he or she could not previously perform because of the serious health condition for which the employee has been on leave?

- No  
 Yes  
 Yes, with restrictions

2. The employee released to return to work effective \_\_\_\_\_  
[indicate date]

3. If the Employee is released to return to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

4. The foregoing restrictions are:

- Permanent  
 Temporary, until \_\_\_\_\_  
[indicate date]

## SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER

DATE