FMLA Return to Work Certification

SECTION I: EMPLOYEE: PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER. THIS CERTIFICATION MUST BE PROVIDED TO YOUR SUPERVISOR PRIOR TO YOUR RETURN TO WORK.

Employee:
Employee's Department:
Employee's Job Title:
Department Supervisor:
Department FAX number:

SECTION II: HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE DEPARTMENT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE.

Please review the attached job description. Is the employee able to perform all the functions of his or her job? ☐ Yes ☐ No ☐ Yes, with restrictions.
Please list any restrictions or functional limitations which the department should consider:
Are the restrictions: ☐ Permanent ☐ Temporary, until (date):
Comments:
Employee is released to return to work effective (date):
Printed Name of Health Care Provider:
Printed Name of Physician:
Specialty:
Address of Health Care Provider:

Signature of Health Care Provider:	Date:

Attn. Supervisors: PLEASE SEND COMPLETED FORM TO HR for employees FMLA file