Medical Leave-Return to Work Form

NOTE: A portion of this form must be completed by a Health Care Provider. A copy of this Medical Certification form must not be in a department personnel file.

PART 1: EMPLOYEE INFORMATION	
Employee Name:	
Dept Name:	
Home Phone:	**Work Phone:**
Home Address:	

Date Leave of Absence (or reduced schedule) **Began**:
Date Employee Will or Did Return to Work at Regular Schedule Hours:
Is the department requiring medical certification that the employee is fit to return to work? Yes No
If Employee is NOT returning to work enter Separation Date :
HR Facilitator's Signature: Date:
Employee Signature: Date:

PART 2: MEDICAL AUTHORIZATION
FOR MEDICAL CONDITION OF THE EMPLOYEE
List essential job duties as well as those that will be affected most directly by absences, treatment, and recovery due to health condition: See job description attached
AUTHORIZATION: I affirm that the information regarding my medical leave request is true and accurate to the best of my knowledge. I authorize of any medical inform to process this request
Employee Signature: Date:

PART 3: CERTIFICATION OF QUALIFYING CONDITION *(to be completed by healthcare provider)*

Name of Health Care Provider:	
Name of Health Care Practice:	
Address:	
Phone:	**Date of Examination:**
Name of Employee:	**Name of Patient:**
Brief Description of Condition:	
Date of Condition:	
Is the employee able to perform the essential functions of his/her position as of the return to work date: Yes No	
Additional Comments:	
CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge	
Health Care Provider Printed Name:	
Signature-Health Care Provider:	**Date:**
Part 4 - Supervisor Signature - Approval to return to work based on above information	
Supervisor Name Printed:	**Date:**
Supervisor Name Signed:	**Date:**