Return to Work Medical Certification

FMLA Leave

PART 1: TO BE COMPLETED BY EMPLOYEE (please print or type)

Employee Name:______________________________________ Date Leave Began: ______________________
(First Name, Middle Initial, Last Name)

Employee Position: ____

Employee Signature: __________________________________ Date: ________________________________

PART 2: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

I certify that on ________________, ____ , is able to resume
(Date) (Name of Employee)

performing the functions of his/her position with or without reasonable accommodation.

Healthcare Provider Signature: ____________________________ Date: ____________________________

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