PAID FAMILY AND MEDICAL LEAVE

Return to Work Authorization

This form must be completed by the healthcare provider before the employee is authorized to return to work following a medical-related paid leave.

EMPLOYEE INFORMATION

EMPLOYEE NAME

EMPLOYEE ID

DEPARTMENT

LEAVE START DATE

HEALTHCARE PROVIDER AUTHORIZATION

PROVIDER NAME

PROVIDER LICENSE/CREDENTIALS

PRACTICE/FACILITY NAME

PHONE NUMBER

RETURN TO WORK STATUS

☐ The employee is fully recovered and cleared to return to work full duty, with no restrictions, effective: _____

☐ The employee is cleared to return to work with temporary restrictions, effective: _____

SPECIFY TEMPORARY RESTRICTIONS (IF APPLICABLE)

ANTICIPATED END DATE OF RESTRICTIONS

NEXT EVALUATION DATE (IF APPLICABLE)

SIGNATURES AND ATTESTATION

I certify that the information provided above is true and accurate based on my professional medical evaluation.

HEALTHCARE PROVIDER SIGNATURE

DATE

EMPLOYEE SIGNATURE

DATE