MEDICAL AND FAMILY LEAVE RETURN AGREEMENT

EMPLOYEE INFORMATION

EMPLOYEE NAME

EMPLOYEE ID

JOB TITLE

DEPARTMENT

LEAVE DETAILS

LEAVE START DATE

APPROVED RETURN DATE

TYPE OF LEAVE

- ☐ Paid Family Leave
- ☐ Paid Medical Leave

RETURN STATUS & ACCOMMODATIONS

- ☐ Returning to full, unrestricted duty.
- ☐ Returning with temporary restrictions/accommodations (documentation attached).

SPECIFIED ACCOMMODATIONS (IF APPLICABLE)

TERMS OF AGREEMENT

By signing below, the employee confirms their intent to return to active employment status on the date specified. The employer confirms the reinstatement of the employee to their former position, or an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment, in accordance with applicable family and medical leave regulations and company policy.

If returning with medical restrictions, both parties agree to adhere to the temporary accommodations specified above, subject to review on the date specified below.

ACCOMMODATION REVIEW DATE (IF APPLICABLE)

SIGNATURES

EMPLOYEE SIGNATURE

DATE

AUTHORIZED REPRESENTATIVE SIGNATURE

DATE