RETURN FROM FAMILY AND MEDICAL LEAVE CERTIFICATION

Directions: This form must be completed by your healthcare provider before you are permitted to return to active duty. Please return this completed form to your Human Resources department prior to your scheduled return date.

1. EMPLOYEE INFORMATION

Employee Name:

_____

Job Title:

_____

Department:

_____

Last Day of Leave:

_____

2. HEALTH CARE PROVIDER CERTIFICATION

Instructions to Health Care Provider: Please review the employee's essential job functions prior to completing this certification. Complete the applicable section below and sign.

☐ **Full Release:** I certify that I have examined the employee and they are fit to return to work full-time and full-duty, without any restrictions, effective as of: _____

☐ **Modified Release / Restrictions:** The employee is fit to return to work with restrictions effective from _____ to _____.

Describe Specific Medical Restrictions / Accommodations:

_____

_____

_____

3. HEALTHCARE PROVIDER DETAILS & SIGNATURE

Provider Name (Printed):

_____

Practice / Clinic Name:

_____

Medical Specialty:

_____

Phone Number:

_____

Healthcare Provider Signature

Date

4. EMPLOYEE ACKNOWLEDGMENT

I understand that I must provide this release to Human Resources and obtain clearance prior to resuming my work duties.

Employee Signature

Date