PAID FAMILY AND MEDICAL LEAVE

Return to Work Form

This form must be completed by the employee and, if applicable, their healthcare provider prior to returning to work from an approved Paid Family and Medical Leave. Please submit the completed form to the Human Resources department.

Section 1: Employee Information

EMPLOYEE FULL NAME

EMPLOYEE ID / NUMBER

JOB TITLE

DEPARTMENT / DIVISION

LEAVE START DATE

PROPOSED RETURN TO WORK DATE

TYPE OF LEAVE TAKEN

- [ ] Medical Leave (Own Serious Health Condition)
- [ ] Family Leave (Care of Family Member / Bonding)

Section 2: Healthcare Provider Certification (For Medical Leave Only)

RETURN TO WORK STATUS

- [ ] The employee is released to return to full, unrestricted duty.
- [ ] The employee is released to return to work with temporary restrictions (complete details below).

SPECIFIC WORK RESTRICTIONS (IF APPLICABLE)

EXPECTED DURATION OF RESTRICTIONS (FROM / TO)

NEXT EVALUATION DATE

HEALTHCARE PROVIDER NAME & TITLE

FACILITY NAME & ADDRESS

PHONE NUMBER

EMAIL ADDRESS

HEALTHCARE PROVIDER SIGNATURE

DATE

Section 3: Employee Acknowledgement

I certify that the information provided on this form is true and accurate. I understand that if my return to work requires modifications or restrictions, those must be approved by my employer prior to my formal return.

EMPLOYEE SIGNATURE

DATE

Section 4: Employer Use Only

HR REPRESENTATIVE NAME & TITLE

APPROVED RETURN DATE

ACCOMMODATIONS APPROVED (IF APPLICABLE)

AUTHORIZED EMPLOYER SIGNATURE

DATE