FMLA Return to Work Form

1. Employee Information.

Employee Name:		Employee ID:	
Deptartment:		Work Phone:	
Employee's Home Address:		Home Phone:	
		Email:	

2. Medical Return to Work Certification (to be completed by the Health Care Provider).

Name of Health Care Provider:			
Name of Health Care Practice:			
Address of Health Care Practice:			
Phone:		Date of Examination:	
Name of Employee:		Name of Patient:	

When is the employee released to return to work?

_____

Is the employee able to perform the essential functions of their position as of the return to work date?

_____

Additional comments:_____

_____

_____

I, the Health Care Provider, affirm that the information provided above is true and accurate to the best of my knowledge.

_____ _____

Health Care Provider's Signature Date

3. Certification of Return to Work (to be completed by the HR Representative).

Date leave of absence began: _____

Date employee returned to work at regularly scheduled hours: _____

Employee **is not** returning to work. Separation Date is:_____

_____ _____

HR Representative's Signature Date