# Return to Work Form

*FMLA*

Because your leave is due to your serious health condition, you will be required to present a release from a qualified healthcare provider authorizing your return to work. If such release is not received, your return to work will be delayed until the certification is provided.

Please return this form or a similar certification from your healthcare provider. Either is acceptable, provided that a return to work date and restrictions, if applicable, are noted. Please provide the completed certification to your human resources administrator and/or supervisor.

## To be Completed by Employee

Last Name: ________________ First Name: ________________ Middle Initial: _____

UFID: ____________________ Phone: _________________

Address 1: ___________________________________________________________________

Address 2: ___________________________________________________________________

City: ______________________ State: _____ Zip: _________________

Department Name: ____________________________________________________________

## To be Completed by Healthcare Provider

Date Employee is released to return to work: _____________________________________

Is the employee able to perform all the functions of his/her job? ☐ Yes ☐ No*

*If no, list any restrictions: __________________________________________________

________________________________________________________________________

________________________________________________________________________

Additional Comments: _________________________________________________________

________________________________________________________________________

Name of Healthcare Provider: _________________________ Phone: _________________

Mailing Address: _____________________________________________________________

City: __________________________________ State: ______ Zip: _________________

Signature: ____________________________________________ Date: _______________