

## REQUEST TO RETURN FROM FMLA LEAVE

Employee's Name	Social Security #
Department	Position
Supervisors Name	Home Phone #

This acknowledges that I am prepared to return to work from my FMLA Leave on

\_\_\_\_\_.

If my FMLA Leave was due to my illness, I understand that I must provide medical clearance signed by my medical provider indicating my fitness for duty and my release date.

Employee's Signature	Date
----------------------	------

---

### Health Care Provider's Statement:

This is to certify that \_\_\_\_\_ may return to work on

\_\_\_\_\_.

Restrictions or limitations?  NONE  Yes

(If yes, explain: \_\_\_\_\_ )

Signature of Health Care Provider: \_\_\_\_\_ Date \_\_\_\_\_

PRINT NAME of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_