REQUEST TO RETURN FROM FMLA LEAVE

Employee's Name:	EIN #:
Campus/Department:	Title:
Name of Supervisor:	Cell #:

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

___________________________.

If my FMLA Leave was due to my own illness or birth, I understand that I must provide medical clearance (below) signed by my medical provider indicating my fitness for duty and my release date. This needs to be submitted to Human Resources prior to reporting to work.

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 restrictions:

____

Signature of Health Care Provider:

____Date____________

Print Name of Health Care Provider:

____ Phone:_________________