Return to Work Medical Certification

PART I: Employee to Complete

Employee Name _____

Position _____

Date Leave Commenced _____ / _____ / _____

Anticipated Return to Work Date _____ / _____ / _____

Employee Signature _____ Date _____ / _____ / _____

PART II: Employee's Health Care Provider to Complete

☐ I certify that _____ is able to resume work
Employee Name

on _____ / _____ / _____.

☐ I have received and reviewed a list of the essential functions of _____'s
Employee Name

position and certify that _____ is able to perform these functions.
Employee Name

Health Care Provider Name _____

Address _____

Telephone Number (_____) _____ - _____

Health Care Provider Signature _____ Date _____ / _____ / _____