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:_____