Request to Return from FMLA Leave

Date: ______________________

Employee Name: ____
Last *First* *M.I.*

Job Title: ____

Home Phone #: ______________ Start Date: ______________________

Supervisor: ______________ Department: ______________________

This acknowledges that I am prepared to return to work from my FMLA Leave on ________________________
If my FMLA Leave was due to illness, I understand that I must provide medical clearance signed by my medical provider indicating my fitness to return to work and my release date.

____
Employee Signature *Date*

Health Care Providers 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: ____

If accepted, confirmation sent to Human Resources for processing: ☐