Military Leave Return-to-Work Certification

Section I: For Completion by SODEXO

Sodexo Contact Information: _____ _____
Name Phone number

Email: _____

Employee Name:_____
First Middle Last

Employee's job title: _____ Regular work schedule: _____

Attached job description (check if attached) ☐ or list employee's essential job functions:

_____

_____

_____

Section II: For Completion by the Employee

Complete Section II of this form and sign it. Give the completed form to your HR or your manager on or before your return-to-work date. *You will not be permitted to return to work until this form is completed and returned.*

Your Name: _____ Your Position: _____

Date Your Military Service Began _____ Date Your Military Service Ended _____

If your military service was more than 30 days, you must attach a copy of document(s) that establish eligibility for reemployment (e.g., DD 214).

If the cumulative total of your military service while you have been employed with Sodexo is more than five years, explain below your military service during this time.

_____

_____

_____

If you could not return to work in a timely manner because you were hospitalized for, or recovering from, an illness or injury incurred in or aggravated during the performance of your military service, describe the medical reason, dates of hospitalization (if any), and recovery below and have your health care provider complete the Certification of Healthcare Provider form on the next page.

_____

_____

_____

I certify that the information provided on this form is true and correct and that I have not been separated from military service with a disqualifying discharge or under other than honorable conditions.

Your Signature: _____ Date: _____

Certification of Health Care Provider for Employee's Service-Related Illness or Injury

Section III: For Completion by Health Care Provider (if applicable):

Instruction to the Healthcare Provider: (Name of Sodexo employee) _____ has been on a Military Leave of Absence from Sodexo and has stated that he or she could not timely report back to Sodexo after the performance of military service because of a service-related illness or injury. Please complete this form and sign below.

Your Name:_____

Type of Practice: _____

Address: _____

Telephone Number: _____ Fax Number _____

I certify that the above-named employee was unable to return to employment with Sodexo within the required USERRA time period because the employee was hospitalized for, or recovering from, an illness or injury incurred in or aggravated during the performance of military service. (Please describe the illness or injury, provide the dates of hospitalization, if any, and the dates of the recovery period.)

_____

_____

_____

_____

Health Care Provider's Signature:_____ Date: _____