FMLA RETURN TO WORK CERTIFICATION

Part 1 – TO BE COMPLETED BY EMPLOYEE:

Employee Name: _____ Lawson #: _____

Employee Address: _____

Employment Location: _____ Unit #: _____

Date Leave Commenced: _____

Date of Planned Returned to Work: _____

Employee Signature: _____

Part 2 – TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER:

The undersigned certifies that on (date)_____, the named employee is able to return to work and resume the duties of employee's position as_____.

- ❒ Without Reasonable Accommodations
- ❒ With Reasonable Accommodations

If accommodation is necessary, it is as follows (please describe in detail):

_____

_____

_____

_____

_____ _____

Signature of Healthcare Provider Date

_____ _____

Print Name of Healthcare Provider Healthcare Provider Phone Number

_____

Healthcare Provider Address City State Zip Code

This form must be completed and sent to the Corporate Human Resources Department prior to the employee returning to work.

Revised 1.1.2022