ILLINOIS INSTITUTE OF TECHNOLOGY

Return to Work Medical Certification

Part I: To be completed by Employee

(Please Print)

1. Name of employee

_____

Last Name First Name M.I.

2. _____

Employee's Position Title

3. _____

Date leave commenced

4. _____

Date of planned return to work

_____

Signature of Employee Date

Part II: To be completed by Employee's Health Care Provider

5. I certify that on _____ (Date) the named employee is able to resume performing the function of his/her position with or without reasonable accommodation. Necessary accommodation(s) is/are as follow(s):

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider Date

*This form is to be given to your supervisor **before** returning to work.*