

# Return to Work Medical Certification

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## Part 1: To be Completed by Employee

(Please print)

1. Name of employee

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Last Name

2. \_\_\_\_\_  
Employee's position title

3. \_\_\_\_\_  
Date leave commenced

4. \_\_\_\_\_  
Date of planned return to work

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

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

5. I certify that on \_\_\_\_\_ the named employee is able to resume performing the function of  
Date

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 taken to Counseling and Health Service, 3300 S. Michigan. Only after being cleared by Health Services will you have the authorization to report to your supervisor and schedule return to work.