FMLA Return to Work Certification

SECTION I: EMPLOYEE: PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Employee:
Employee's Department:
Employee's Job Title:

SECTION II: HEALTH CARE PROVIDER: PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE HUMAN RESOURCES DEPARTMENT, BY FAX, (406) 327-2151, OR EMAIL, DEPARTMENTH@CI.MISSOULA.MT.US, PRIOR TO THE RETURN TO WORK DATE.

Please review the attached job description. Is the employee able to perform all the functions of the job? ☐ Yes ☐ No ☐ Yes, with restrictions.	
Please list any restrictions or functional limitations which should be considered:	
Are the restrictions: ☐ Permanent ☐ Temporary, until (date):	
Comments:	
Employee is released to return to work effective (date):	
Printed Name of Health Care Provider:	
Printed Name of Physician:	
Specialty:	
Address of Health Care Provider:	
Signature of Health Care Provider:	Date: