

**FMLA/Extended Leave Return to Work Certification Form**

Because your leave is due to your serious health condition, you will be required to present a release from a qualified health care provider authorizing you to return to work. If such release is not received, your return to work may be delayed until the certification is provided.

**Section I: To be completed by Employee**

Name: \_\_\_\_\_ Z #: \_\_\_\_\_

Department: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Note to employee: If you believe you have a medical condition that is affecting a major life activity and your ability to perform the essential functions of your job, and you believe you need a reasonable accommodation, you must contact the Office of Equity, Inclusion, and Compliance at (561) 297-3004 for information regarding the request for accommodation process under the Americans with Disabilities Act.

**Section II: To be completed by Health Care provider:**

Provider's name and business address: \_\_\_\_\_

Type of practice/medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Return to Full Duty

Date Employee is released to return to **full duty and no work restrictions**: \_\_\_\_\_

Return with Work Restrictions

Date Employee is released to return work **with restrictions**: \_\_\_\_\_

Work Restrictions (please be specific as possible):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Duration of above listed medical restrictions: \_\_\_\_\_  
(if date not known, please provide the date of the next appointment)

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax completed form to Division Employee Relations and Development, Department of Human Resources at **561.297.1256** or email **emprels@fau.edu**.