FLORIDA ATLANTIC UNIVERSITY

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 Civil Rights and Title IX 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**.