Notice of Intention to Return from FMLA Leave

Employee Full Name (print): _____

Supervisor: _____ Employee's Position:_____

Date leave commenced: _____ Job Description Provided: ☐ Yes ☐ No

Returning to work on the date released: ☐ Yes ☐ Delayed, due to bonding time of a newborn - Expected Date: _____

I understand that my restoration to employment is subject to the following conditions:

1. I was advised, prior to the date of this Notice, that as a condition of restoration, I would be required to provide a written certification from my health care provider that I am able to resume working and can perform the essential functions of my job. My health care provider has reviewed documents related to the essential functions of my job and their certification is indicated below.
2. I was advised, prior to the date of this Notice, that upon my return to work, every attempt would be made to restore me to my original position. I was advised and acknowledge that if my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits. Key employees (as defined by the Department of Labor) may be excluded from this provision.

Employee's signature Date

Healthcare Provider Notes:

Your patient has requested to return from leave under the FMLA. Answer, fully and completely, all applicable parts. Some questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can. Limit your responses to the condition for which the employee sought leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Provider's name (Please Print): _____

Type of practice / medical specialty: _____Telephone: (_____) _____

1. I have examined (employee) and certify that she/he is able to resume work without restrictions. ☐ Yes ☐ No

Effective Date the employee can safely return to work: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

Frequency of episodes/treatments/appointments (i.e. event): _____ Times per ☐ Days ☐ Weeks ☐ Month
Expected Duration of episodes/treatments/appointments: _____ Hours _____ per event

Healthcare provider's signature Date

NOTE: This form should be provided to the department's Human Resources Coordinator.