REQUEST TO RETURN FROM FMLA LEAVE

Employee's Name	Social Security #
Department	Position
Supervisors Name	Home Phone #
This acknowledges that I am prepared to return to work from my FMLA Leave on	
If my FMLA Leave was due to my illness, I understand that I must provide medical clearance signed by my medical provider indicating my fitness for duty and my release date.	
Employee's Signature	Date
Health Care Provider's Statement:	
This is to certify that	may return to work on
Restrictions or limitations? NONE Ye	es
(If yes, explain:)
Signature of Health Care Provider:	
PRINT NAME of Provider:	Phone: