Instructions: Any employee who is absent from work due to an injury or illness and sought medical treatment must submit this form, signed by a health care provider, certifying that the employee is able to return to his/her position and perform the essential job functions with or without reasonable accommodations.

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| --- | --- | --- | --- |
| **I. To be completed by Employee** |  | | |
| Name | Period of Absence | From: | To: |
| Department | Expected Date of Return | | |
| Job Duties (be specific)  Position description is attached (preferred) | | | |

|  |  |
| --- | --- |
| II. **To be completed by Health Care Provider** |  |
| The above-named employee may return to work on: | |
| The employee may perform the above-listed duties:  Without accommodations.  With the following accommodations: | |
| Additional comments: | |

Signature of Health Care Provider Date

Printed Name of Health Care Provider Telephone No. Fax No.