PART 1: TO BE COMPLETED BY EMPLOYEE (please print or type)

Employee Name: ___________________________ Date Leave Began: ___________________________
(First Name, Middle Initial, Last Name)

Employee Position: ______________________________________________________________________

Employee Signature: ___________________________ Date: ___________________________

PART 2: TO BE COMPLETED BY EMPLOYEE’S HEALTH CARE PROVIDER

I certify that on __________________, ___________________________ , is able to resume
(Date) (Name of Employee)

performing the functions of his/her position with or without reasonable accommodation.

Healthcare Provider Signature: ___________________________ Date: ___________________________