Exhibit C

F AMILY AND MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

9/96

This section to be completed by the employee:

Employee: _____

Employee's Department: _____

Department Contact: _____

Telephone Number : _____

This section to be completed by Health Care Provider
PLEASE COMPLETE THE FOLLOWING AND RETURN TO THE DEPARTMENT PRIOR TO THE RETURN TO WORK DATE:

Please review the attached job description. Is the employee able to perform all the functions of his or her job?

❑ yes ❑ no ❑ yes, with restrictions or accommodations

Please list any restrictions or accommodations which the department should consider:

Are the restrictions: ❑ Permanent ❑ Temporary, until (date): _____

Comments:

Employee is released to return to work effective (date): _____

Name of Health Care Provider: _____

Specialty: _____

Address:

Place address stamp here.

_____ _____

Signature of Health Care Provider Date