

**CENTRAL TEXAS COLLEGE
FAMILY/MEDICAL LEAVE ----- RETURN TO WORK
MEDICAL CERTIFICATION FORM**

Human Resource Management Policy #390: Family Medical Leave Act of 1993

Please Type or Print

PART I: TO BE COMPLETED BY EMPLOYEE - SIGNATURE REQUIRED	
1. Name of Employee: (Last Name, First Name, MI) _____ SSN: _____	2. Job Title: _____ Department: _____
3. Leave Start Date: _____	4. Actual Return to Work Date: _____
5. Employee Signature: Signed: _____ Dated: _____	
PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER	
6. I certify that on (Date) _____, (Name) _____, can perform all of the functions of his/her position <i>with/without</i> (Please circle one) limitation or accommodation.	
6a. If job functions are limited or if accommodations are necessary, please complete below:	
Limitation(s): _____ _____	
Accommodation(s): _____ _____	
Anticipated date that employee can perform all of the functions of his/her position without limitation or accommodation: Date: _____	
Signed: _____ Dated: _____	
7. Health Care Provider's Name, Address and Telephone Number: _____ _____	
PART III: TO BE COMPLETED BY EMPLOYER	
Employer Remarks: 	

3 Copies Required: Original to Employment Services; Copy 2 to Supervisor; Copy 3 to Employee