

**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

<b>PART I: TO BE COMPLETED BY EMPLOYEE - SIGNATURE REQUIRED</b>	
<b>1. Name of Employee:</b> (Last Name, First Name, MI)  <u>  Doe, Jane R.  </u> SSN: <u>    111-11-1111  </u>	<b>2. Job Title:</b> <u>  Clerk III  </u>  <b>Department:</b> <u>  Systems  </u>
<b>3. Leave Start Date:</b> <u>    01/02/06    </u>	<b>4. Actual Return to Work Date:</b> <u>            02/28/06            </u>
<b>5. Employee Signature:</b>  Signed: <u>  PLEASE SIGN, DATE AND RETURN TO EMPLOYMENT SERVICES  </u> Dated: <u>          </u>	
<b>PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER</b>	
<b>6. I certify that on (Date) <u>  02/27/06  </u>, (Name) <u>  Dr. John Smith  </u>, can perform all of the functions of his/her position <i>with/without</i> (Please circle one) limitation or accommodation.</b>	
<b>6a. If job functions are limited or if accommodations are necessary, please complete below:</b>	
Limitation(s): <u>  None  </u>	
Accommodation(s): <u>          None          </u>	
<b>Anticipated date that employee can perform all of the functions of his/her position without limitation or accommodation:</b> <p style="text-align: right;">Date: <u>  02/28/06  </u></p>	
Signed: <u>  THE PHYSICIAN MUST SIGN AND DATE HERE  </u> Dated: <u>          </u>	
<b>7. Health Care Provider's Name, Address and Telephone Number:</b> <u>    SCOTT &amp; WHITE HOSPITAL, TEMPLE TEXAS    </u>	
<b>PART III: TO BE COMPLETED BY EMPLOYER</b>	
<b>Employer Remarks:</b>	

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

02/06