



# SEDGWICK COUNTY FMLA RETURN TO WORK CERTIFICATION

**This form MUST be submitted to HR at least two (2) business days prior to the projected return to work date.**

**Employees may not be permitted to resume work if this form has not been submitted.**

**Complete employee information ONLY. If you have been absent for your OWN serious health condition (including pregnancy), have your Health Care Provider complete Part II. If your continuous leave has been for any other reason, submit the form directly to Human Resources upon completing the Employee section.**

## **PART I: EMPLOYEE MUST COMPLETE THIS SECTION**

Employee Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Department \_\_\_\_\_

I certify that on \_\_\_\_\_, I will resume performing the functions of my position and have notified my supervisor.

**Returning from**      Employee's Continuous Medical Leave      Continuous Leave for covered family member  
**CHECK ONE:**      *(Part II must be completed by medical provider)*      *Includes returning from Baby Bonding Leave*

**Employee**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PART II: TO BE COMPLETED ONLY BY HEALTH CARE PROVIDER DUE TO EMPLOYEE'S OWN MEDICAL LEAVE**

**Upon review of the employee's job description (attached), I certify that:**

- The employee is released to work as of \_\_\_\_\_ (mm/dd/yyyy).
- Upon returning to work, the employee is able to perform all of the **ESSENTIAL JOB FUNCTIONS** and **PHYSICAL REQUIREMENTS** of the position:  
     Yes      Yes, with restrictions in place until \_\_\_\_\_      No, proceed to Question 3

List all restrictions given to the employee: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- If the employee **CANNOT** perform all the **ESSENTIAL JOB FUNCTIONS** and/or the **PHYSICAL REQUIREMENTS** of the position, please list the specific **TASKS/DUTIES** that are unable to be performed:

\_\_\_\_\_  
\_\_\_\_\_

- Is the employee able to return to work and resume job responsibilities without posing a significant risk or substantial harm to themselves or others?      Yes      No

5. Additional Comments: \_\_\_\_\_

\_\_\_\_\_

Medical Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT Healthcare provider's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Full Business Address of Provider: \_\_\_\_\_

**Fax completed form to Sedgwick County Human Resources at 316-941-5132**