

HEALTH CARE PROVIDER CERTIFICATION TO RETURN TO WORK

EMPLOYEE INFORMATION (to be completed by the employee)**PLEASE PRINT**

Last Name _____ First Name _____ Middle Initial ____ BGSU ID _____

Street Address _____ City _____ State _____ ZIP code _____

I have been away from my job on a University leave as denoted below **(Check All that Apply)**.

Family & Medical Leave (FML)

Extended Medical Leave of Absence

Workers' Compensation

This form must be **fully completed and returned to the Office of Human Resources at least two (2) days prior** to your return to work. **Return form to:**Office of Human Resources
1851 N Research Drive, Room 106
Bowling Green, Ohio 43403**ATTN: OHR/FMLA**

419-372-8422 (Business Telephone) / 419-372-2920 (Fax)

HEALTH CARE PROVIDER INFORMATION (Complete the following for the employee to return to work)

The employee is released to return to work on _____ (date)

The employee is released to work on _____ (date) **with** the following restriction(s)***Restriction(s):****How long** will the employee likely be under these restrictions?_____
Health Care Provider's Signature_____
Date of Signature_____
Printed Name of Health Care Provider_____
Business Telephone_____
Street Address_____
City_____
State_____
ZIP Code*** Disclaimer – Some positions with restrictions may not be able to be accommodated.**