TEXAS WOMAN’S UNIVERSITY
FMLA RETURN TO WORK MEDICAL CERTIFICATION FORM

PART I: TO BE COMPLETED BY EMPLOYEE

Employee Name: ___________________________ Dept: ___________ Job Title: ___________________________

Patient Name (if different): ___________________________ Relationship to Employee: ___________________________

I understand that I am responsible for obtaining information from my health provider to give additional or clarifying information that would assist in the determination of qualifying for benefits. In compliance with HIPAA Medical Privacy Rules, my signature indicates my permission for the health care provider to release any and all information as requested on this form for clarification of individually identifiable health information.

Employee Signature: ___________________________ Date: __________________________ Contact #: __________________________

PART II: TO BE COMPLETED BY THE PHYSICIAN OR PRACTITIONER

Is the employee able to return to work and perform the functions of the employee’s position? (Answer after reviewing the job description from the employer showing the essential functions of the employee’s position.)

☐ Yes, is able to return to work and perform essential functions of the job. If yes, please enter return to work date.

Return to Work Date: __________________________

☐ No, is not able to perform all of the essential functions of the job. If no, please continue to next question.

Please explain restrictions on essential functions that the employee is unable to perform (attach additional documentation if necessary):
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Dates of duration of restriction: from: ___________________________ to: ___________________________

Is the employee currently able to work his/her regular schedule? ☐ Yes ☐ No

If no, will be it necessary for the employee: (check one)

☐ To be absent from work intermittently from (dates) _______________________ to ______________________

☐ To work less than a full work schedule from (dates) _______________________ to ______________________

☐ To not work at all from (dates) _______________________ to ______________________

Printed name of Physician or Practitioner: ___________________________

Type of Practice (field of specialization, if any): ___________________________

Address of Physician or Practitioner: ______________________________________________________________

Phone Number of Physician or Practitioner: __________________________ Fax Number: ______________________

Signature of Physician or Practitioner: ___________________________ ______________________

Please Return to the Office of Human Resources: Holly Harris
PO Box 425739
Denton, TX 76204-2739 Phone: 940-898-3542 Fax: 940-898-3566

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