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:___________________________________ _________________________
Date

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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